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The Anatomy and Clinical Applications of Group Interaction

S. R. SLAVSON

EVERY DIRECT HUMAN ENCOUNTER generates interaction. The interaction may be slight or intense, implicit or explicit, verbal or nonverbal; whether the results are made manifest or not, everyone involved undergoes transient internal change in thought and/or feelings with concomitant somatic and psychic processes, that is, psychosomatic phenomena which, according to the nature of the protagonists or the conditions in which the confrontation occurs, may set off benign or malignant interpersonal responses. The reactions may be withheld, suppressed, or acted out in accordance with the regulative principles characteristic of each of the persons involved.

Nietzsche once remarked that when two persons meet, they at once understand one another, but later they talk each other out of it. First impressions are modified or altered for one of two reasons. One stems from social mores and the prevailing culture which extols benevolence in attitude and restraint in conduct. Harboring negative feelings is considered "bad" and "sinful." To gain acceptance and approval, one must be, or act as though one is, accepting and tolerant. Subverting the negative puts one in the company of the good and righteous. Another motive for suppressing or withholding intuitively arrived at negative feelings may be for social or material advantage. According to the nature of the motivation, alienative feelings may be an index of maturity or the road of opportunism.

The foregoing is a view of confrontation from its negative aspects. But confrontations also evoke positive and mutually beneficial responses leading to synergic thought and/or action. The point is, however, that all human contacts initially activate some degree of uncertainty and anxiety, for neither of the participants is completely at ease, nor is he certain in advance of the reactions of the other, nor does he know when and how his threat areas will be assailed. This is as true of group encounters as it is of a dyadic relationship, although degrees and intensities of the two may differ. The natural and automatic effect of a group upon its participants has been described as "group-induced anxiety" (Slavson, 1964). Due to the unavoidable emotional networks that arise in small groups, they quantitatively present greater threats to their constituents than are evoked in a dyadic encounter. The heightened quantum discomfort arises from two genetic sources. One is the variety in the styles of ego functioning of each of the participants and the unpredictability of developments. The other source is the phalanx that groups tend to form for the possible victimization of one member of the group.

The style and intensity of threat varies to a considerable degree with the cultural level of the participants. The quality of the interaction is to a telling extent determined by the level of ego functioning of the group's members. Their ego controls determine their tolerance or intolerance toward the idiosyncrasies of fellow members. A group, even one with benign social aims, may, under some circumstances, end in a fiasco. However, barring such an extreme, ordinary groups, that is groups with no therapeutic intent, operate under varying degrees of restraints. Ordinarily, brawls, for example, occur only in specific strata of society, and usually only when individuals are under the influence of restraint-dissolving agents such as alcohol or drugs.

Groups in which the discharging of feelings is encouraged and in which there is frank interchange of undisguised positive and negative attitudes among their members are the psychotherapy groups. Maximum latitude reigns in these, as well as in all other respects, and patients subjectively react and interpersonally interact freely, often discharging raw feelings without restraint or regard for social amenities—a situation that in any other type of group could not be tolerated.

The type and intensity of individual internal reactions are conditioned in early childhood and reflect the "culturalizing" influence of homes and neighborhoods. By culturalizing is meant the success with

which sublimational channels for primitive responses and ego controls are established during the formative years of an individual. These two factors and successful repression determine the capacity for interpersonal relations and interactions. Overcathexis of feelings, opinions, and convictions—which is usually a defense against doubt and insecurity—leads to overassertiveness, stubbornness, and combativeness, which in ordinary life exist to a minimal degree in the cultivated (not necessarily schooled) person.

Despite antecedent educational and culturalizing influences, invidious mechanisms are heightened by ordinary events in emotionally disturbed individuals who constitute the membership of therapy groups. By and large, the individual re-enacts in his interpersonal relationships response patterns of his formative years, and by their permissiveness and emotional intensification, therapy groups maximize individual patterns of response. The overtly aggressive person becomes more aggressive, the covertly aggressive person throws off restraints, and the frightened, timid, and diffident are abashed by the conduct of their fellow members and may (and certainly do at the outset) withdraw into silence.

In the climate of a therapy group, where regression is encouraged, disagreements, conflicts, and rivalries inevitably emerge, as do affinities, often of a pathogenic nature. These constitute important grist for the psychotherapeutic mill. The psychotherapist understands these phenomena as manifestations of the transference–countertransference dynamic stemming from earlier phases in the psychic development of the individuals involved. He also knows that they are essential to the reconstruction of the damaged personality. However, it is important to keep in mind that the ultimate therapeutic value of such phenomena does not lie in the re-enactment or in the emotional release achieved through them. These aberrant reactions and interactions are steps toward acquiring understanding and insight into the motives and needs they serve in the psychic economy of patients. Release of affect may reduce tensions, but its ultimate value lies in the insight it can give into the individual's specific psychodynamics.

In other papers (Slavson, 1957, 1960), I have attempted to identify the specific characteristics of therapy groups as opposed to those of other groups existing in a free and fluid society such as ours. By virtue of these differences, the usual controls for dealing with what is ordinarily viewed as deviant and disturbing behavior are not applicable to groups with a

therapeutic aim. Neutralization, compromise, assimilation, cohesion, polarity, synergy, and the like are not available to the therapist and his group as they are to the leader of a social club, or an educational, political, or special interest group. Were they to be applied in a therapy group, the group's therapeutic objectives would be annulled. Contrariwise, other group phenomena and interactive mechanisms that do not occur at all or only minimally in other types of groups constitute the very essence of a psychotherapy group. Among the dynamics that most often occur in therapeutic groups are mutual induction, (emotional) interstimulation, and rivalry. And the greater their intensity, the better do they serve the group's objectives.

Psychological phenomena in all groups stem from three sources: reenactment, acting out, and abreaction. In nontherapeutic groups, the cohesive forces stemming from commonality of purpose, interest, or aim keep these primary trends in abeyance. When they do appear, the leader and the group members either prohibit their full exercise or they are controlled by the cohesive group forces such as the primary group code, social mores, and intrapsychic inhibitions, or they are resolved through the mechanism of compromise which naturally arises in ordinary groups. In contrast, in psychotherapeutic groups, where the primary group code permits and encourages freedom of action and expression, these and other disruptive eruptions are the meat of therapy. In their climb to mental health, patients in group psychotherapy must reveal to themselves and to the other group members their *real* selves; they have to throw off their façade of polish and deportment, and they must rid themselves of culturally imposed, noxious pseudo defenses and build in their stead more healthful and more appropriate defenses and controls.

The group, and even more so the therapist, is thus faced with the problem of permitting the free flow of infectious negative and disruptive manifestations while still confining them within bounds consistent with therapeutic demands. The management of outbreaks in the permissive climate of psychotherapeutic groups requires, in addition to an unusual degree of objectivity and self-control on the part of the therapist, a thorough understanding of the latent content of the proceedings. The therapist must be able, from his knowledge of the individual operational patterns of his patients, to identify the sources of the outbursts and the deviant attitudes and the characteristic behavior of the instigator, as well as the others, involved in a rally or transaction. As is the case in all

types of groups, the therapist must perceive from which of three possible sources behavior stems—whether the instigator's and the respondent's behavior is motivated by re-enactment, acting out, or abreaction.

I have attempted on a number of occasions to stress the point that every response on the part of a therapist, verbal or nonverbal, must be therapeutically appropriate and specific to the current transaction, particularly to its latent content. The behavior of patients in the permissive setting of the therapy group may easily try the patience and psychic tolerance of the psychotherapist, generating countertransferential, covert, and at times even overt, reactions on his part. Aside from the therapist's superior ego integration and maximal emotional noninvolvement, one of the important safeguards against the arousal of countertransferential feelings and conduct is the *understanding* by him of the compelling forces operating in the patients' psyches. This is the *sine qua non* of therapy, for such knowledge produces suitable attitudes and leads to appropriate conduct. The therapist realizes that the patients' behavior is inevitable and, because of their condition, is beyond the scope of their responsibility at the time. This attitude of the therapist is that of the true healer, which sets him apart from most persons the patients have encountered in the past.

In line with these principles, the therapist, to be effective in dealing with difficult or disruptive behavior in individual or group therapeutic settings, must be aware of the meaning and sources of behavior. Only by acting upon such knowledge can the therapist utilize the patients' reactions for therapeutic ends. For example, seemingly infantile irascibility, uncontrollable temper, or unreasonable narcissism may need to be differentially overlooked, encouraged, restrained, or explored. The decision rests upon the clinical indications for a specific patient at a given time and/or the psychic tolerance of the other patients.[1] The therapist needs to draw upon knowledge of the patient's dominant current psychodynamics and their earlier formative influences and conditions to determine the most appropriate course of action or inaction. Inappropriate dealing with the behavior will not only prove to be a disservice to therapeutic outcomes but, what is even more disastrous, it may seriously vitiate or entirely destroy the positive transference toward the therapist.

[1] The other group members are inevitably drawn into such tensions and conflicts, which means that their effect on the group as a whole needs to be considered. Such tensions usually set off irritation or aggression through countertransferential reactions, interstimulation, mutual induction, and scapegoating trends.

RE-ENACTMENT

Re-enactment in human relations stems from re-awakened psychic and neuronic reflex reactions established during the developmental phases of the individual. Reactivations are set off in circumstances that appear to be similar in basic respects to traumatic events of the past. The very group compresence, for example, may awaken anxieties and aggressions in individuals whose early multiple relations in the original family were a source of threat, tension, and pain.

The therapist needs to be alert to the difference between idiosyncratic character structure and behavior which can be misconstrued as re-enactment. Character patterns arise from the imprinting upon the child by his environment, by identification and imitation of significant models, and by his interaction with them. The totality of demands, pressures, and influences—modified to some degree by later accommodations—together with their emotional concomitants, shape almost mechanically an individual's entity. Conduct arising from the individual's entity can be described as "characteristic." When it is socially deviant or problem-generating, the behavior is described as that of a person with a character disorder or one with general maladjustment.

The roots of re-enactment under consideration here, on the other hand, lie not in habit and in conditioning but in the suppressed emotivity of earlier phases of development. The re-enactment is colored by automatically arising pain, anxiety, guilt, and hostility called forth or re-awakened by a current situation. In other words, it is part of the *neurotic* (as differentiated from the purely *neuronic*) structure of the individual.

In view of the neurotic nature of the impulse and the pattern employed in discharging it through re-enactment, the uncovering procedure is appropriate for dissolving the anxiety bound up in it. After permitting the irrational behavior to spend itself, the therapist helps the patient, at the appropriate time and by the appropriate uncovering technique, to trace the emotional relationship between his current feelings and the prototypes of his past. Reliving the antecedent situations and releasing the emotions bound up in them is the core of the treatment.

To employ such an analytic procedure would obviously be entirely counterindicated, as well as ineffective, when the behavior proceeds from primary character conditioning. In re-enactment, the ego of the neurotic

is overpowered by an impulse which, in a more tranquil state, would be ego-alien. In a character disorder, on the other hand, the ego is an integral part of the complex, that is, the behavior is ego-syntonic; and, therefore, the ego cannot be enlisted, as it were, in the reconstructive process. This is the chief reason why group therapy is the treatment of choice for patients with character disorders. The nature, setting, and interactions in groups are such that earlier psychic imprintings can be weakened and to some degree eradicated, even in adults, and new ones established, thus effecting character and behavioral changes. For the same reasons, groups are particularly suitable for child patients. Being still in the preneurotic stage in their development, children can be reshaped by a favorable active milieu (Slavson, 1942). This is true, too, for a large segment of disturbed adolescents (Slavson, 1965a).

Although rarely, it is occasionally necessary in clinical practice to recommend that some individuals with character disorders, such as psychopaths, hardened delinquents, and criminals, be committed to punitive institutions where their survival as social atoms is threatened and their deeply repressed anxieties aroused, thereby breaking through their narcissistic character-defense armor (Slavson, 1954). Perhaps this is what is meant by the euphemistic statement of turning a character disorder into a neurotic. When anxiety is aroused by the punitive regimen, the inmate tends to seek relief through communication, and when this sharing is with a trained therapist, he can be led along the path of unraveling the source of his difficulties.[2]

ACTING OUT

Acting out in psychotherapy is resorted to by patients as an avenue of release that does not entail the risk of self-revelation to others and to oneself. Recourse to acting out is a characteristic of the regressive or infantile-fixated individual who has a need to cling to his defenses to prevent damage to his self-image and injury to his self-esteem. To achieve

[2] I formulated the thesis of the unavailability of deeply repressed anxiety during the preverbal and pregenital phases in the psychopath's development during my early work with children (see "Contraindications of Group Therapy for Patients with Psychopathic Personalities," Slavson, 1945). The efficacy of a conditioned environment in breaking through resistive character armor was discovered in 1935-36 in an institution for delinquent adolescents (Slavson, 1942), and the effect of a more punitive milieu in another project in 1957-1961 (Slavson, 1965b).

these ends, he resorts to withholding revelatory verbal communication. This aggressive pattern, manifested either in action or in irrelevant verbal effusiveness, serves to drown out anxiety. In the psychoneurotic, acting out is motivated by a fear of instinctual impulses and of revealing them, and for preservation of the rigidly defended self-image. Acting out can also be a symptom of an inadequate ego development which permits the ascendance of impulse. (The latter may inhere in the character organization as well as being a neurotic manifestation, and the therapist needs to be alert to this difference.) Thus, acting out can be (1) character-based, (2) defensive, or (3) a strategy of concealment.

1. An individual who has lived in a family with a prevalent culture of acting out of feelings and aggressions adopts this type of response as a matter of course by identification and imitation. The early pressures for adoption of a specific conduct shape the nature and intensity of the acting out syndrome later in life. Infantile-based syndromes can be reshaped to varying degrees by a conditioning culture or environment such as a group or any other therapeutic instrumentality in which the external situation exerts corrective pressures and demands. Therapeutically oriented interpersonal exchange in a group, reinforced by explanation and interpretation, tend to diminish this type of acting out syndrome.

2. Defensive acting out is part of a neurotic syndrome and is strongly guarded. Assailing it directly, as is done in the case of characterological acting out, would not only further damage the patient's personality but may drive him from the therapeutic arena. Treatment of neurotic acting out is facilitated by groups, but in many instances individual psychotherapy is essential to eliminate the intrapsychic compulsions from which the neurotic acting out stems. Reactions from a group of peers are, with some exceptions, a salutary adjunct to individual psychotherapy. The group's responses and the controls it exerts as substitutes for the primary family are more likely to affect the patient's behavior than is the overt or implied criticism of the parental figure represented by the therapist. However, the group alone cannot nullify the internal conditions that beget the behavior, and the behavior will reappear after termination of group treatment.

In neurotic acting out, infantilism or arrest in development is also an ever-present element. This is attested to by impulsivity and physical or motoric reactions which are remnants of the infantile ego. Because of this infantile characteristic, the patient is susceptible to yielding to group

pressure, provided it is not violent and does not attack his defense system too early. It is the therapist's function to protect him against these eventualities or to cushion their impact when they do occur. However, his main task, as well as the value of the group encounter to the therapeutic effort, is to improve the defenses in the service of which the acting out operates. The psychoneurotic patient needs to be placed in a situation in which he is sufficiently comfortable to reveal to himself and to others the hitherto-guarded noxious feelings, values, and attitudes that have been inadequately held in repression or are still in concealment in his unconscious and subconscious. This requires regressive catharsis and revelations which some patients are unready to make in a group. In such instances, the basic therapy must be on an individual basis, either exclusively or paralleling the group.

Many psychotherapists find it necessary to "work through" basic problems with some of their patients *preliminary* to their being included in groups. Some patients may require both individual and group psychotherapy from the outset. With different levels of the psyche being reached by the dual approach, eventually a degree of integration is achieved and one of the therapies, usually the individual treatment, can be terminated. A third approach is to carry the patient exclusively in individual psychotherapy until the deeply entrenched psychoneurotic syndromes have been sufficiently resolved and then to taper off therapy by placing the patient in a group so that he may test his insights in interpersonal interactions. Often, psychoneurotic patients have to be returned briefly to individual therapy for further work on specific problems which the comparatively diluted therapeutic climate of the group still cannot reach.

Neurotic defensive acting out is regarded in the same light as any other type of neurotic symptom, but with the added facilitation of a group to affect the *character element* involved. The procedures suggested are discriminately employed to supply the therapeutic needs of different types of patients; specifically, the differential quantum and character of their psychoneurotic and character components.

3. The concealment aspect of acting out usually disappears as the ego of the patient is strengthened and the need for such defenses in his psychic economy ebbs. Calling attention to a patient's evasiveness or assailing it in any other way is always risky before the ego is able to deal with such exposure. However, at times and with some patients, this may

be necessary, if so, it calls for the therapist's best judgment and the exercise of great caution. When possible, it is always best to await the automatic dissolution of such noxious defenses when they no longer serve the ego and self-image needs of the patient as he emerges into health.

ABREACTION

The term *abreaction* as it is used here refers specifically to verbal or motoric behavior set off by a disturbing or conflictual experience which does not serve to resolve a traumatic complex; rather, it serves to discharge heightened emotivity to re-establish emotional equilibrium. It has been pointed out by some writers that abreaction is at times in the service of resistance. I am disinclined to agree with this characterization. Abreaction is resorted to by countless people in innumerable situations in everyday living, frequently in mystifying forms and always inappropriately. The victims of abreaction are usually innocent persons who are at a loss to understand the reasons for their being harassed. A classical and commonly quoted example of abreaction is the man who is angered in the office and kicks the dog upon arriving home. Another is the man who instigates a quarrel with his wife or kicks a chair as a reaction to his suppressed rage toward his boss.

These and similar acts, unrelated as they are to the cause of provocation, serve as conduits for discharging irritation or rage and for neutralizing of the excess adrenaline that rage draws into the blood. This frees the organism of the stimulant through muscular action and reestablishes psychoorganic homeostasis. When this process involves verbal interaction as in a therapy group, considerable violence may be set off. The fact is that the original causal disturbance may not always be generated in the group. Not infrequently patients appear at a session in a state of agitation generated elsewhere in their contacts and pursuits. In this state, they may explosively and unreasonably criticize or attack the therapist or fellow patients; or they may briefly withhold their irritation until some gesture or remark triggers it. The resulting tirade may be directed at these persons or at some target unrelated to the group. Such a target may be a general or special social phenomenon or a personal conflict having an identifiable bearing on the group or its proceedings.

The therapist must be vigilant against making an entirely under-

VECTORS OF INTERACTION

Elsewhere (Slavson, 1964), I have outlined the variety of vectors of interaction. I have listed them as occurring patient-to-patient, patient-to-group, and patient-to-therapist; to this list may be added group-to-therapist and therapist-to-group. This staggering network of emotionally charged attitudes and feelings, which are always present in overt and covert states in a freely interactive psychotherapy group, is so immensely complex that the instrumentality of an electronic computer would be required to unravel it. A glimpse of this magnitude can be gained from the mathematically possible number of interactions to *any one* stimulus or situation in a group of eight persons. On the basis of the formula suggested as applicable to this phenomenon (Slavson, 1944), $S = n(n - 1)$ $(n - 2) (n - 3) \ldots (n - n + 1)$ in which $n = 8$, the number of interactions would be 16,320. Considering the multitudinous stimuli in a group of emotionally heightened persons, the possibilities for interactions are astronomical. At times, the therapist may be hard put to steer the group's course toward therapeutically valid sequences. However, there are usually dominant "themes" and "rallies" operating in groups at any given time. These are self-selective as to the content and direction of the group's common preoccupation. It is these which the therapist utilizes in the therapeutic endeavor, and it is on the basis of these that he helps the group and its individual members arrive at therapeutically gainful understanding and insight.

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A Self-Help Project with Hospitalized Alcoholics

FRANCIS M. CANTER, Ph.D.

GROUP PSYCHOTHERAPY IS ONE of the most widely used and highly re-
garded treatment approaches with hospitalized alcoholic patients. How-
ever, there are certain problems with the use of this technique which
make modifications or additions to it desirable. Hospitalized alcoholics
are usually very passive in any sort of treatment situation. They tend to
be authority-oriented and covertly rebellious, which results either in
nonparticipation or in subtle forms of sabotage or avoidance, such as
endless talking about alcohol or putting the burden of "entertainment"
upon the therapist. Alcoholics often have great difficulty in relating what
they have experienced in group therapy to their actual problems of
adjustment, which can give rise to a striking disparity between "insight"
and subsequent practice. A particular problem is the alcoholic's resistance
to "psychological" treatment approaches (Franks, 1963) and a preference
for "rehabilitation" programs or, at least, activities which de-emphasize
any implication of "sickness" or psychiatric disorder.

The Alcoholics Anonymous approach, as successful and useful as it
has been with many patients, also presents problems with the hospitalized
alcoholic patient. Its strongly religious character is unpalatable or anxie-
ty-arousing to many patients. The emphasis upon acceptance of help-
lessness and "surrender to a higher power" can be a further threat to
the already shaky self-esteem of an alcoholic. Furthermore, A.A. pro-
grams in hospitals differ from community groups in that patients are
frequently not a truly voluntary or cohesive group.

Nevertheless, the example of A.A. is a powerful one and suggests a

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line of development for programs to involve the alcoholic patient in his own treatment. Although not referring to alcoholics specifically, Mowrer (1964) commented on the inefficacy of any "treatment" that does not place the responsibility for recovery squarely upon the patient, and he attributes the increasing popularity of "self-help" organizations to a dimly sensed awareness that conventional psychiatric approaches remove this responsibility. The problem of "motivation" is referred to frequently in the professional literature on treatment of the alcoholic (Sterne and Pittman, 1965), although any discussion of it usually contributes no more than the admonition that the patient must be motivated.

This paper describes an experimental project at a large state hospital with a high admission rate (28% of total admissions) of alcoholics. The project grew out of staff discussions of the problem of involving the patients in their own rehabilitation. Specifically directed toward trying to give alcoholic patients a sense of responsibility and initiative and the opportunity to exercise these, the program attempted to involve them without the requirement of admission of "illness," on the one hand, or "surrender," on the other. The therapists functioned only as advisers and "facilitators," giving assistance or guidance when requested but resisting "doing for" the patients. Their intent was to help the patients see where their problems lay and how they could best handle them on their own.

THE SETTING

The patients were male and female alcoholics, admitted via court commitment only, most of them relatively unwillingly, at least at the verbal expression level. They were housed in two separate, cottage-type wards, one for each sex, and took their meals on these wards. The period of hospitalization averaged three months and usually terminated in complete discharge, only rarely in leave status. Visits away from the hospital were allowed in the event of emergency only, although visits from relatives were unrestricted. All patients had "open ward" privileges and participated in the activities of the hospital, such as dances, movies, etc. The treatment program was a conventional one involving group therapy, didactic lectures, and discussions, A.A. meetings, and the usual medical-physical rehabilitation, choice of Antabuse, etc. The average age of the patients was in the early forties, and the average educational level was high school or less. Occupationally, the patients were housewives, clerical

workers, salesmen, small tradesmen, skilled or semi-skilled workers, and farm laborers. About two-thirds had families who retained some interest in them. At any one time, both wards had a population of about one hundred. During the period of the writer's contact with this project, more than twelve-hundred patients were "exposed" to the project and participated in it to some degree.

The professional and rehabilitation staff was minimal in terms of staff-patient ratio but included physicians, psychologists, social workers, rehabilitation therapists, and nursing personnel, although some of these were only part-time on the alcoholic wards. During the period of the project, the "regular" treatment program continued. Thus, impressions of the results are based upon the pre-project treatment compared with this treatment plus the project. It was not feasible to design a situation in which the project would be substituted for the regular hospital program because of certain practical and administrative difficulties. Furthermore, the project was originally conceived as an adjunct to the regular program to improve participation in it.

THE PROJECT

As indicated, the project grew out of staff dissatisfaction with patient participation in, and response to, the regular treatment program. The project was initiated with a mass meeting of the staff and patients at which the patients were asked what they expected from their hospitalization, what they wanted to accomplish, and how they viewed the present program. It developed that few of them had any clear-cut idea of what they wanted but many had complaints about this or that aspect of the program, up to and including complete rejection of it. It was suggested that the patients form "committees" to prepare recommendations about the program and to take steps to change it where possible. After considerable initial resistance, a complaint committee was organized to receive, process, and "take action" on complaints about the hospital and program, an education committee was designated to prepare a better program, and an after-hospital planning committee was formed to devote itself to questions of obtaining employment, a place to live, and funds to get started on for patients discharged from the hospital.

Group meetings were held at regular intervals to discuss the progress and problems of the committees. Within a few weeks, a more or less

workable structure had developed that included a number of active committees and a format of operation. A committee consisted of an elected chairman and co-chairman and a variable number of voluntary members. All patients were urged to serve on a committee, and those patients who did not were sought out for assistance by various committees at different times for specific projects. Patients could be—although they usually were not—members of more than one committee.

The executive committee, consisting of the chairmen of the other committees, coordinated activities. The education committee prepared programs for meetings, obtained speakers and movies, and arranged informal discussion sessions. The ward-improvement committee sought ways to improve the appearance and efficiency of the living quarters. The recreation committee planned parties and dances. The finance committee arranged for contributions for refreshments, postage, and a "slush fund" to help outgoing patients. The publicity committee sought to keep all patients and the hospital in general aware of the activities of the project, primarily through articles in the hospital newspaper and programs on the hospital closed-circuit TV station. The original complaint committee, interestingly enough, quickly expired, and such matters were taken over by the executive committee or other appropriate committees. The after-hospital planning committee became quite active and important, compiling a list of halfway houses and treatment facilities in the nearby communities and arranging interviews with employment agencies and employers.

One or more weekly meetings involving all patients were held at which a speaker on some subject of interest and relevance made a presentation and led a discussion, or a movie on alcoholism or mental health was shown. The education committee made the arrangements, contacting speakers by phone or letter. The speaker might be a staff member of the hospital or an outside community person, such as the local sheriff, who talked on alcoholism as he saw it, or the head of an employment agency, the director of a nearby private sanitarium for alcoholics, or custodians of halfway houses. Interspersed with the formal presentation meetings were "bull-session" discussions on any topic which arose. The individual committee meetings also served as informal discussion sessions, and many of the meetings became the setting for searching self-examination by the patients.

Recruitment of new members for the committees was a constant

activity because of the high rate of patient turnover. A welcoming committee contacted each new patient, explained the project, and invited the patient to participate. Usually, a follow-up was required; later in the project, a "sponsor" system was adopted in which each member sought out and tried to involve at least one new patient.

Many discussions were held concerning the purpose of the project, and at times the patients were hard put to state just what they were doing or trying to do. Eventually, however, they arrived at a fairly stable goal definition, which was "return to society," a choice that seemed to reflect an awareness of the degree to which they had become socially estranged. Specifically, they worked toward self-education concerning alcoholism in its various aspects, a recovery of initiative in running their own lives, a restoration of self-esteem by means of proving that they could do things effectively, and a successful transition back to the community after hospitalization.

The place and function of the ward staff changed somewhat during the course of the project. At first, it was envisioned that the staff would stand on the sidelines, as it were, and take no part in the project. This turned out to be unworkable, and soon members of the staff were drawn into roles as "advisers," particularly in helping the patients thread their way through the complex hospital regulations concerning patient activities. At no time did staff members set any rules on how the project was to be structured or run. (Exceptions were those few instances in which the activities concerned other wards and had, necessarily, to conform to hospital regulations and the demands of the personnel of those wards; mainly involved was the recruitment of alcoholic patients who happened to be housed on other wards.) Early in the project, it became clear that the patients wanted the active interest of the staff, even though they simultaneously wanted to retain control of the actual operation of the project. In patient-staff meetings, considerable care was taken to keep the discussion on the level of practical problem-solving, without digression into personalities, without interpretation of behavior, or "psychologizing." Matters concerning the project were dealt with by the staff only if the patients could not solve the particular question for themselves.

TASKS AND PROBLEMS

From the outset, the project encountered difficulties and at times seemed almost on the verge of collapse, but always it rallied and regained

momentum. Throughout, there were realistic problems of conflict with hospital regulations and with staff members who either did not approve of or who misunderstood the project, or both. There was resistance to allowing patients to assume responsibility and to function in relatively unsupervised ways. Many staff members viewed alcoholic patients as nuisances unworthy of time and attention, as "hopeless cases," or simply as irresponsible wrong-doers to be criticized, rejected, and used as "free labor." Consequently, the enthusiasm with which patients flung themselves into the project was frequently dampened by the hostility or indifference which they met with. Some staff members, while offering verbal support for the idea of the project, subtly sabotaged it by throwing up roadblocks in the way of the patients' independent action and by downgrading their very real accomplishments. Some of the staff, long accustomed to dominating and directing the patients, appeared to feel threatened by the independence of the patients and attempted to reestablish controls by imposing arbitrary restrictions and reminding the patients "where they were" and what their "real" status was.

And, of course, many patients were only too ready to meet such resistance or controls by surrender and passivity or withdrawal, or by a childish rebelliousness and plaintiveness. The patient-staff meetings characteristically opened with a series of accounts of failures and assessments of blame. These were discussed by the staff in objective terms and related to the kinds of problems which would be faced by the patients in their home or work situations. The meetings frequently ended with the recognition that some of these problems would have to be met with compromise, different tactics, or perhaps strategic withdrawal until more favorable circumstances could develop.

There was a considerable amount of intragroup conflict, with rivalry for positions of importance and mutual recriminations for any failure of group efforts. Some patients with leadership capabilities would become very enthusiastic and active, then feel disgusted or rejected when their efforts were not apparently appreciated. They would abdicate from the group or fall into a pattern of blaming everything on "lack of motivation and interest" in the patient group (in effect, copying the previous pattern of staff reaction). In a few instances, a felt failure or rebuff resulted in the patient going AWOL from the hospital; one patient got obviously drunk on the ward. Some patients found it difficult to accept the leadership of another patient and kept turning to the staff for confirmation or permis-

sion and guidance. Naturally, a considerable amount of "politics" was evident in obtaining election to certain offices, though an associated problem was the reluctance of patients to accept the responsibility of some positions (and the work that went with them).

Patients in key positions would occasionally leave (discharge or AWOL) without passing their office on to someone else. This meant that a new office-holder would take over knowing little or nothing of what he was supposed to do and what had been done by his predecessors. The difficulties caused presented a clear-cut object lesson in responsibility to others. Over a period of time, the patients worked out written instructions concerning procedures, but more importantly, they began to take responsibility for personally communicating the information to those concerned.

The average period of activity for a member in a group was a little more than two months, and at times it seemed as if the whole effort of the project was being devoted merely to sustaining itself. However, this turned out to be a vital benefit of the project since patients were required to seek each other out and do a "selling job," which made for a definite change from the previous apathetic atmosphere in which patients scarcely knew each others' names. It also presented new patients with a model of active, participative behavior from persons with whom they could more readily identify than with the hospital staff. This "modeling" (Bandura and Walters, 1959) is one of the major ingredients of new behavior patterns.

The relationship between the project and the hospital's Alcoholics Anonymous program, which was conducted by community chapters, was a curious one and highlighted the similarities and differences in approach. Naturally, there was considerable overlap in membership, and some of the leaders in the project were also active in A.A., but the overlap was attenuated by the fact that only patients on the alcoholic wards were in the project, whereas alcoholic patients from other hospital wards could and did attend A.A. The A.A. program was fairly standard, cut-and-dried, and "establishment" in character, whereas the project was constantly exploring, trying new approaches, reorganizing, actively recruiting members, and making community contacts. The leaders of A.A. tended to look down their noses at the project and rarely made reference to it (though very much aware of its activities), while patients active in the project tended to take a critical, competitive attitude toward A.A. and clearly conveyed their sense of being a younger sibling. Project-oriented

patients were more judgmental and analytic about people who were recommitted to the hospital because of drinking, whereas A.A.-oriented patients rarely mentioned relapses.

A considerable number of patients became disillusioned with and deserted A.A. to become active in the project, but very few did the reverse. This is probably because of the selection factor involving "activists"; passive patients who joined either group remained, regardless of felt benefit, whereas active patients preferred a more dynamic and expressive role than A.A. permitted, at least in the hospital setting. A.A., in accordance with its traditions, simply held its meetings, which were "open" to anyone who wished to come whereas project members did a considerable amount of missionary work and managed to convey an attitude of interest and concern to new or unassociated patients. (At the same time, this insistence and enthusiasm tended to irritate some patients, who then went to A.A. meetings as a kind of retaliation.)

Not surprisingly, it was continually evident that the patients were quite dependent on the staff for encouragement, praise, occasional advice, and general moral support. These were not so much deliberately sought as evidenced in the general discussion sessions, in the meetings with the executive committee, and in the regular group therapy meetings (where project matters were frequently brought up). This dependency was understood and handled, not as an indication of failure of the project's aims of developing responsibility and independence, but as an inevitable stage in the process of developing an identification with models, i.e., the staff members, who behaved in responsible, interdependent ways. A direct copying of certain ways of behaving of influential staff members was observed in some members of the project in their relationships among themselves, in ways of conducting meetings, etc.

It should be emphasized that the project in no way represented a "ward government" or "therapeutic community" situation. Its aims were explicitly those of providing each patient with an opportunity to become active in his own "treatment" and to develop, in association with others, an orientation toward an active, seeking, responsible understanding and handling of his drinking problem. The patient group had no disciplinary or advisory function for infractions of rules or for general operation of the wards. There was no attempt (indeed, it was carefully avoided) to explore individual interpersonal difficulties or attitudes. Nor did the project represent any sort of "puppet" program, foisted off by the staff

on the patient group, though there was an element of that in the beginning perhaps. In fact, at times when staff interest in the project was flagging, patients who were members of the project went to considerable effort to revive staff confidence and enthusiasm with new schemes, proposals for broader operations, etc.

RESULTS

With the institution of the project, a definite and continuing change was observed in general ward atmosphere and in the somewhat intangible but very real variable of "patient attitude." Naturally, this was not reflected continually nor by every patient and was only noticeable to those staff members who had been active on the wards for some time previously and to returnee patients who had been hospitalized prior to the project. One of the most obvious changes was in the general appearance of the wards and the grounds. The ward-improvement committee was quite active in making the most of the considerable potential for beautification of the grounds and in creating something of a hospital showplace of the wards. The patients took pride in noting inadequately functioning equipment and either made the necessary repairs or pressed the staff to do so. It was noted that patients made many more references to "our ward," and any criticism of the building, grounds, staff, or program were apt to be taken personally by the patients. The staff noted less difficulty in getting patient help with unpleasant jobs, and there were fewer complaints about the facilities.

A second, very obvious area of change was in the direction of interest away from immediate personal concerns or grievances and toward the welfare of others. Two programs were developed by the patients on their own initiative: one to assist with the handling and training of mentally defective patients on the hospital's wards for such patients, and one for assisting with the care of geriatric patients, including escorting them to church and card parties. The program with the geriatric patients was particularly successful, and project members participated well in it. In addition, these activities contributed to a noticeable improvement in the attitudes of the staff on nonalcoholic wards toward the alcoholic patient.

There was evidence of increased concern on the part of the patients with their "image" in the eyes of the hospital staff, nonalcoholic patients, and the public. One result of this concern was the presentation of programs on the hospital's closed-circuit TV station which attempted to tell

something of the alcoholic's problems and the purposes of the project. There was greater willingness to meet with visiting professional and student groups to discuss the problems of alcoholism. When there arose a threat to statewide alcoholic programs through possible loss of funds, the project patients responded by a letter-writing campaign to the governor and the state legislature. Letters were also written to local radio and TV stations and to newspapers requesting support for continuation of the programs or thanking them for support given. This was done on the patients' own initiative and without staff pressure.

A type of missionary activity to community facilities developed, and at least two "graduates" of the project (who had been signal failures after previous hospitalization on the same wards) went on to active community work of an educational and consultative nature. One patient, in working with a local legal officer, set up regular "classes" of an informational and guidance nature for alcoholics. The after-hospital planning committee established relationships with halfway houses and employment offices and developed plans for an after-hospital "graduate" organization to lend continuing support and assistance in a community from which many of the patients came.

Partly by word of mouth and partly from articles in the hospital newspaper, which was sent to appropriate community agencies and individuals by project members, the project became quite well-known, and, in fact, some agencies and individuals thought it was the only alcoholic treatment program offered in the hospital. This was partly a reflection, no doubt, of the enthusiasm, not to say bias, with which the program was described by the project's publicizers. This result was not viewed with complete favor by A.A.-sponsoring groups and by some staff members, who did not like being considered appendages of the project, but most recognized it as a positive indication of the increased activity and interest of the patients.

Generally, there appeared to be *greater* involvement of individual patients in the various aspects of the treatment program, and involvement, of some sort, of *more* patients than before the project was initiated. Patients who had been relatively unresponsive or resistant to A.A. and the conventional psychological or medical approaches were caught up to some degree by the activities of the project. (There were still, of course, some patients who were responsive to nothing and simply passively awaited discharge or else went AWOL, but the proportion of these was

smaller than previously.) It would be a mistake to confuse mere activity with constructive self-rehabilitation, and in some cases it did seem that the patients were merely engaging in much busy-work but little meaningful assumption of responsibilities. Nevertheless, the activity and involvement of most of the patients served as a focus of motivation, i.e., it pointed toward something direct and positive which they could do for themselves and for others (rather than merely a negative "not drinking").

ADVANTAGES AND DISADVANTAGES

The project filled a gap between the A.A. approach and the more intensive psychological group therapy led by the staff. Patients who could not accept either the submissive, religion-oriented, and self-punitive program of A.A. or the searching and anxiety-arousing aspects of psychotherapy were able to engage in a mutually supportive, self-controlling, and ego-skill-oriented program which contributed to a renewal of self-respect and self-confidence without development of antagonism and rebellion toward the staff or families. This was a particularly gratifying development in view of the fact that almost all of these patients had been unwillingly committed to the hospital. (Interestingly, most of the patients who were willing "volunteers" into the hospital tended not to get involved in either the project or in psychotherapy, but gravitated toward A.A.)

There was a distinctly better relationship between the staff and patients as a result of the project (except for those few staff members who felt threatened by the patients' assumption of responsibility and initiative). The image of the alcoholic as a person trying to help himself came into more prominence, and there was less of the negative stereotype of the alcoholic as simply a lazy, incorrigible, or bad person.

The activities and the interpersonal relations stimulated by the project provided relevant, reality-oriented material for the regular group psychotherapy sessions. Patients were able and willing to discuss these matters, whereas there was apt to be reluctance or distortion in discussion of relationships outside the hospital.

On the other side of the fence, the project was time-consuming and frequently caused bickering, confusion, and conflict with other hospital personnel when the project members did not use tact in program arrangement or in recruitment of new members from other wards, or in demands

for attention or services from others. Some patients, as previously mentioned, simply used the project activities as a way of passing the time until discharge, or attempted to convert them to their own purposes and dropped out if they did not succeed. There was continuing confusion with A.A., which tended to take a dim view of the whole proceedings, particularly since many people referred to the project as "A.A." Some staff members felt that there was a diversion of energy and purpose from more intensive group psychotherapy approaches and that the project was mostly a form of entertainment and denial.

SUMMARY

The project has been a worthwhile and interesting experiment in developing motivation and involvement in the treatment program. It uses an approach which appeals to the alcoholic's need for a feeling of importance, does not demand that he first consider himself a "sick" person, and provides opportunities for actual experience in working in a cooperative manner with others. The project was based on Goethe's dictum that one should not accept people as they are but as they ought to be so that they are enabled to become what they are capable of becoming. While such a project as described here in no way represents a substitute for either individual or group psychotherapy, A.A., or conventional medical-psychiatric approaches, it adds a dimension to the overall treatment program which contributes to the development of involvement and motivation and encourages both staff and patients to pay attention to the patient's positive resources and ability to behave in active and responsible ways.

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Phobics in Group Psychotherapy

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A PHOBIC PATIENT BELIEVES that he is the only one who has such an absurd symptom. Destroying the illusion of uniqueness can be the first step in assisting the patient to mobilize his defenses, attain a healthier compromise, and eventually achieve a better adjusted life.

Because many phobics have a major dependency figure in their lives and, in individual psychotherapy, the shift of dependency from the familial figure to the therapist hinders their recovery, group psychotherapy would seem a more suitable modality of treatment. In the group psychotherapy literature, however, many authors refer to phobics as not suitable for this type of therapy. Some indicate that the results are poor even if the patients can be persuaded to remain in treatment. There are few, if any, mentions in the literature of therapy groups consisting only of phobic patients. In this paper, an attempt is made to outline the major difficulties, pitfalls, and advantages of such a group.

FORMATION OF GROUP

Patients diagnosed as "phobic neurosis" were seen for one week in individual psychotherapy and were informed of the possibility of the formation of a group in the near future. Each person's reaction to the idea of group therapy was the same: he wondered whether he would be accepted by the other group members; he shared the magical thinking of "harming" or "being harmed" by saying or hearing the wrong thing at the wrong time; and he expressed fears of picking up other people's symptoms.

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Eight of 12 phobic patients agreed to join the group. The other four continued individual psychotherapy but withdrew in a short time, usually with the statement that the crisis that had brought them to the clinic had passed. Six of the eight patients attended the first meeting; the other two patients did not volunteer an explanation for their nonappearance. The six patients had been seen individually for an average of eight one-hour sessions, while the six nonparticipants had been seen only for an average of two to three sessions. The group of six met for one and one-half hours weekly for nine months. During the first five months, each patient was seen for one additional hour weekly in individual psychotherapy. At the start of the sixth month, individual psychotherapy was discontinued with the understanding that it could be started again at the patient's request. Initially, it was thought to be desirable to have both males and females in the group; however, of 17 patients evaluated as candidates for the group, there was only one male, so the idea was abandoned. Later, an attempt was made to add new patients, but it proved impossible to keep them in the group, as will be explained later.

GROUP MEMBERS

Case 1

Mrs. S. N. was a 30-year-old, white housewife who consulted the clinic because of fears of going out or driving her car alone. She was able to shop and be in a crowd if accompanied by her mother. Mrs. N. was the oldest of three sisters. She had to leave high school in her senior year to get married because of pregnancy. She is now the mother of three boys, 13-year-old twins and a six-year-old. In the course of her 13 years of marriage she had been separated several times. She gave numerous reasons for not holding a steady job to support herself and her children while she was separated. Her family, who had always supported her, put pressure on her to reunite with her husband to avoid divorce. Her husband worked as a truck driver and drank heavily. He objected violently to his wife's seeing a psychiatrist. In the group she was the most talkative member. She identified herself with the group and depended heavily on its support.

Case 2

Mrs. J. B. was a 32-year-old, white housewife who consulted the clinic because of fears of driving downtown and being in crowded places such

as elevators, parties, etc. Mrs. B. was the youngest of three sisters. She had two daughters, 11 and 12 years of age. Her husband was the manager of a construction company owned by his parents whom he frequently consulted in regard to the work. He spent a good deal of his free time in stag bars. At home, Mrs. B. made all the family decisions. Her parents were advanced in age and depended on her for their day-to-day life, shopping, banking, etc. She had a fifty-year-old married "boy friend." Three years previous to this time her husband found out about the affair and threatened divorce if she did not break it off. She continued to see the man, however, even though she felt humiliated because he flatly refused to consider marrying her. In the group she was a chronic complainer, with a new complaint each week. The group tolerated her and envied her for having a boy friend. They ridiculed her about his age, but they accepted her as she was.

Case 3

Mrs. C. B. was a 36-year-old, white housewife who consulted the clinic in a panophobic state; she was afraid of staying in the house, of going out, of strangers on the street, etc. She was the older of two siblings and the mother of four children. Her husband was a crane operator and a heavy drinker (probably an alcoholic). He often stayed overnight with friends or girl friends, and she accepted and tolerated this behavior. She was active in the church and other social organizations and reached out to a lot of people in her environment. She had been witness to a car accident in which, she found out later, her husband's girl friend had been killed. Since that time her husband's drinking sprees had become less frequent and he spent more time at home with the family. In the group, she was emotionally detached but participated often in intellectual discussion. The group looked upon her as an experienced, "mature" woman.

Case 4

Mrs. J. B. was a 34-year-old, Negro housewife who consulted the clinic for agoraphobia and anxiety attacks. She was the only patient in the group with two years of college education. The second oldest of six siblings, she was herself the mother of six children. Her husband, who was 17 years older than she, worked as a laborer and drank heavily. Six years previous to this time she had left her husband for two years to live with a boy friend. She was not able to get a divorce, and eventually, bow-

ing to family pressure, she returned to her husband. In the group she was quiet but participated in the discussion with a little encouragement.

Case 5

Miss C. K. was an 18-year-old, single, white woman who consulted the clinic because of acute agoraphobia and claustrophobia. She was the youngest person in the group and the only one who was single. She lived a promiscuous life and associated with a lower class of boys. She lived with her 66-year-old, widowed mother. The mother-daughter relationship was tense and they fought continuously. She herself was tense and anxious and often had to leave the group for the bathroom.

Case 6

Mrs. C. H. was a 26-year-old female, newly married for the second time. She consulted the clinic because of claustrophobia and agoraphobia. She lived with her mother and five other members of her family. While she was dating her present husband, she started to have severe anxiety attacks every time she was left alone. During a brief courtship her husband felt his fiancee needed more love and hurriedly married her and moved in with the family. He very soon found that "love wasn't enough," and he was forced to quit his job as a painter to keep her company. In the group she was anxious and tense most of the time. She made brief remarks and comments but seldom talked for any length of time. She listened attentively to everything that went on and discussed it with the therapist in her private sessions.

GROUP INTERACTION

The group passed through three phases. Phase I started with the members introducing themselves to each other by describing their symptoms and the years they had been tormented with them. Some members exaggerated their symptoms, making themselves the sickest; others related shocking material to the group about their infidelity and dishonesty and then withdrew completely. Because the sessions were not structured and the topic discussed was left to the members, disorganization and gradual regression became apparent in the group. There was a marked increase in dependency on the leader, and he was looked upon as an omnipotent doctor. The members related to him as if they were in an individual session, and all discussion was directed to him.

The therapist felt it necessary to change his approach, and he began to participate actively by directing the discussion and structuring it as much as possible without taking the initiative away from the group. Detailed histories and patients' views on certain topics were known to the therapist through the individual sessions, so he sometimes invited opinions if he thought it would be relevant and therapeutic.

In the individual sessions, the patients all expressed a feeling of being "tricked" into a normal group just to see how they would react. Each member felt that the others were just "faking" and were "attention-seeking." They were encouraged to discuss these views in the group, and later they did.

Phase II started about the time of the sixth session, when group members began to develop a closeness to each other. To some, this was frightening and they attempted to fend it off by listing the numerous difficulties they had undergone to attend the session and then asking, "Is it really worth it?" In this phase the group discussed problems exclusively sexual or aggressive in nature. The most intimate sexual fantasies (some never talked about in individual sessions) were brought up for discussion. Unusual, murderous thoughts were disclosed.

In the ninth session, Mrs. C. B. (case 3), announced that she was thinking of quitting the group. She explained that she had come to therapy with many different fears and that she had now overcome them and her goal was accomplished. The rest of the group reacted to her claim of being "cured" by enumerating other symptomatic behaviors and emphasizing the point that she did not know why she got sick in the first place. They frightened her with the possibility of getting sick later with a new set of symptoms. When Mrs. C. B. appeared at the tenth session, she was obviously embarrassed and burst into nervous laughter. She said that a thought had flashed through her mind: "I have a crush on the doctor, and I said to myself, this is ridiculous." She added that the group had helped her a lot and so she was considering continuing with it. After this incident the group started an open struggle to win the leader's approval. They reported efforts to overcome their phobias. The therapist encouraged this move and minimized failures by praising the members' determination to help themselves. In a matter of a few more weeks the group was almost phobia-free.

In the fourth month the group was informed that the regular individual sessions would be discontinued after four weeks but that if anyone

felt the need he could ask for a private session. Mild protests and feelings of rejection were dealt with in the subsequent private sessions.

In Phase III, the cohesiveness and the solidity of the group grew, and their ability to discuss and evaluate their problems improved. They became less dependent on each other and moved to the outside, renewing old friendships they had let slip because of their illnesses. At this stage the leader was considered part of the group, and they agreed and disagreed with him as they wished; he was the omnipotent doctor no more but simply the group leader. After nine months, it was felt that the goals of the group had been attained, and the group was disbanded.

DISCUSSION

It was felt that a strong rapport between patient and therapist would be essential in order to maintain the phobic patient in group therapy; thus, three months was considered a minimum period of preparation for the group. The combination of group and individual therapy allowed the doctor-patient rapport to be maintained at its strongest after group therapy began. The patients utilized the individual sessions to discuss the anxiety generated in the group meetings. This increased the patients' willingness to participate in the group discussions and eventually to become more involved. Initially, dependency on the leader was increased, but the therapist's willingness to accept and meet this need helped to hold the members in the group. As fears of criticism and disapproval from the group were alleviated, a mutual givingness and support for each other held the group together.

The main group discussions were of sexual and aggressive behavior, which dovetails with the dynamic aspects of phobia. Also, the group was made up of young, attractive, fairly intelligent women, and all of them, with one exception, were married to heavy drinkers or work addicts, and sexual frustration and repressed hostility were the main issues in their lives.

Three months after the group began, we attempted to add new members but were unsuccessful. The new patients were seen for a shorter period (only three visits), and perhaps not a strong enough rapport developed to keep them in the group. A second factor was that the group had matured and the new members felt like outsiders regardless of what we attempted to do. And the group at that time was in the process of giving

up their phobic symptoms and checking on each other every session; thus the new members felt tremendous group pressure to abandon their symptoms before they were ready to.

In this limited experience, group therapy was considered to be more valuable for phobics than individual psychotherapy for the following reasons: (1) The sibling rivalry to win the leader's attention and approval became a most helpful tool for the therapist to use in helping the patients to give up their symptoms and adopt a healthier and better adjusted way of life. (2) Group pressure was directed at a clear-cut target. (3) The group was found to act as a buffer against despair and hopelessness. The members were able to pull each other out of depressive episodes and help in critical situations. (4) The group served as a small social nucleus. The patient learned and unlearned social behavior which they tested and tried for its appropriateness and inappropriateness. (5) The group gave the patient a sense of belonging and identity, which, in turn, helped them to separate themselves from pathological dependency relationships with their families. (6) The group gave the members an immediate social reward for behavioral changes, which reinforced and enhanced further change. (7) There was a sincere and genuine social relatedness which helped the members to develop more social responsibility and to relate to each other on a more mature level.

SUMMARY

A therapy group for phobic patients has been discussed. The resistance to joining group therapy was higher than in the average group, and a longer preparation stage was designed to overcome this hurdle. The group dropout rate was high, and adding new members was difficult. It was felt that individual sessions in conjunction with the group meetings were very important in keeping the patients in the group and in dealing with immediate problems. It was felt that the group sessions had many advantages over individual sessions. The outcome of this group suggests that patients who undergo group therapy in conjunction with individual sessions overcome their phobias faster than do patients in individual treatment alone.

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Reaching the Rejects through Multifamily Group Therapy

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CHILD GUIDANCE CLINICS HAVE long been concerned with the fact that traditional therapeutic methods result in a high proportion of failures. In our clinic, patients with relatively little formal education and from lower socioeconomic backgrounds and patients from broken families have been particular problems. Motivating and sustaining treatment has presented many difficulties, and withdrawals from treatment often occur before hoped-for goals can be reached. In effect, these cases are clinic failures.

If the word "reject" is used to describe these failures, the question is whether we have rejected them for their "lack of motivation" or whether they have rejected us because our programs have been too rigid and have not been attuned to their particular problems and needs. Over the past several years, we have given this latter hypothesis much thought.

Despite their many differences, all of these families shared common features, namely, a lack of involvement with themselves, each other, and/or with their community; an ignorance of, or blindness to, possible alternative family organization; misinterpretation of social rules; a lack of knowledge of the varieties of social interaction open to choice; and severe blockage in open communication within the family context. Because of the closed or shut-off quality arising from these interactional difficulties, we chose to call these families "isolated." We felt that putting several

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families of this type in a group together might make them focus upon their isolation. Theoretically, the multifamily group would offer several advantages: the other families would function as a mirror for a specific family's alienation, and the group could represent the broader framework of the social milieu or, alternatively, operate as an enlarged family setting.

For a period of three years, we ran five groups, each consisting of three families, making a total of 15 families. Each group of three families consisted of the mothers, the fathers, and the designated child patients, with siblings introduced when it was considered appropriate. For the first year and a half, our main focus was upon communication, and we were interested in how this emphasis would affect the "isolated" family.

We became aware during this period of the impact that this mode of therapy was having on families who could be classified either as psychologically naive or socioeconomically deprived. To explore this further, we scrutinized the background of each family involved in the groups and administered psychological tests to both adults and children. We noted that several group members who were limited in education and whose I.Q.'s were in the lower range of the test results of the entire group rapidly became astute in their understanding and interpretation of the psychological interaction taking place. Interpretations which had been difficult for this population to comprehend in individual sessions seemed more meaningful and easier to grasp by virtue of the concrete behavioral examples that were readily available in the multifamily group.

To test this finding further, we selected that part of our clinic population who were extreme in terms of being psychologically naive and socioeconomically deprived. These were Negro families with broken homes. The children had been referred to the clinic for a myriad of symptoms, from socially acting out to severe underachieving in school, with more than one symptom applicable to each child.

The group consisted initially of six mothers and eight children, with two other siblings added at a later date. The group was seen for 10 months by a male and female co-therapist. At the time of the group's termination, it consisted of four mothers and seven children. One mother withdrew her two children from treatment because she stated that her health did not permit her to come on a weekly basis; however, this same mother has since reapplied to the clinic and has asked to return to "the group." One mother withdrew her child from treatment because of frustration with the initial problems concerning group attendance. Four

families remained throughout the year, with the primary patient being seen initially and siblings being introduced as the year progressed.

GROUP COMPOSITION

The first family was a mother and her 11-year-old son who was an illegitimate child. He had never known his father. In the school setting he had been both a behavior and learning problem. He tended to be a clown, both to offset, and in preference to, being a scapegoat. He was fearful of fights and of being attacked and would run away rather than defend himself, a fact his mother deplored. She had transferred him from public to parochial school, hoping that the increased discipline in this setting would solve his problems. When they persisted, she applied to our clinic. The mother, while ostensibly a passive woman, was very controlling and difficult to reach. When she first entered the group, she was obese and obviously very sensitive about her weight since she never removed a loose-fitting coat which served her as a shield. In this family there were two younger sisters, aged six and five, who did not attend the group.

Another family consisted of a mother and two children: an illegitimate daughter who was nine years old and a son aged 11. The mother was divorced from the boy's father. The girl was doing poorly in school and had difficulty getting along with other children. She lied persistently in school and at home. The relationship between her and her mother was very poor. The boy, whom the mother preferred, was also becoming a behavior problem in school and was doing poorly in his work. He became a group member after the group's inception. The mother was a sensitive, bright woman who held a responsible job in a large organization. She tended to be overly serious at all times and quite unhappy about her problems with her daughter.

A third mother came with an eight-year-old boy who had severe asthma attacks in addition to his other problems. He was doing very poorly in school, had a serious reading block, and seemed determined to remain infantile and keep the mother bound in a symbiotic relationship, a goal with which she cooperated. Her older son, who was 12, joined the group at a later date. He was also having school problems and felt isolated at home and in school. At school he was a target for more belligerent, aggressive boys since he was very small for his age. He, too, was afraid of being beaten up and was apparently afforded no protection by the school

authorities. The mother was a bright but exceedingly suspicious and angry woman ready to interpret much that went on about her as an attack, insult, or manifestation of racial prejudice. The two boys had contact with their father, who was a heavy drinker with a volatile temper. Their visits with him always held a potential for disaster, which all too often came true.

The fourth mother in this group brought in two sons aged 10 and 11. There were three other children in this home and an illegitimate grandchild. None of these other children participated in the group. The parents were divorced, and the father had little, if any, contact with the family. The younger boy, whom the mother favored, was a serious behavior problem in school. Shortly before coming to the clinic, he had been picked up by the police for stealing. The mother, an attractive, soft-spoken woman, who was very responsible in her job, revealed little feeling openly. She seemed quite bland and undisturbed on the surface about this boy's behavior and had all sort of excuses for him. The bulk of her irritation was with the older boy, who had lived for many years with a doting aunt and uncle. She resented the fact that he preferred to live elsewhere, and she complained of his fighting with his younger brother, the designated patient. She did not see any relationship between her own preference for the other children in the family and this boy's unhappiness at home.

Three of the four mothers in the group worked to support their families. The fourth mother was on welfare.

COURSE OF THE GROUP

In contrast to the intact families in our previous groups who came from a higher socioeconomic segment of the community and with whom attendance had been excellent, this group initially had serious attendance and lateness problems. Whereas in most groups both lateness and consistent absences become a group issue, in this group they did not. The mothers did not censure each other on either score. What members of most groups would have considered lack of self-discipline or lack of organization in managing their lives, they forgave each other. In the order of hierarchical importance of maintaining jobs, paying the bills, and keeping the family together, there was little doubt that clinic attendance and promptness were low on the list. The pressing problems of everyday

living took precedence over therapy. Interpretations by the therapist that absence or lateness was resistance drew little reaction. In view of our decision to key ourselves to the needs of this particular group, we did not persist in confronting this behavior. At about the three-month mark, attendance began to improve and soon ceased to be a problem, with the exception of one mother. Improvement in lateness fluctuated. The fact that we did not persist in interpretations appeared to be helpful in increasing the involvement of the group with the therapists.

We felt that part of the initial difficulty in making this array of families into a group lay in their unspoken resentment at its being a segregated group. Although we tried to bring this out into the open, it was an issue they bypassed. Several of the children, less guarded initially than the adults, refocused the problem more concretely upon the therapists' position as "white" authorities, comparing us with school personnel with whom they were having difficulty. Dealing with the issue in this form, plus our efforts to keep within the group's frame of reference, seemed to contribute to a quicker dropping of defensive attitudes. The segregation issue was, thus, not utilized as resistance. Instead the homogeneity became a tool for dealing with common problems. Only in the angry, suspicious mother did resentment still seem to smolder at the group being nonintegrated. With her, it played a role in her initial rejection of all interpretations made by the therapists and in her determination to fight the group all the way. A change in this attitude was brought about primarily by her younger son becoming more verbal in the group. His participation exposed to the other members of the group his attempts, in many ways successful, at manipulating and controlling his mother. The seductive interplay between the mother and the child became apparent. This was interpreted by the group, and the mother was then forced, not only to examine how destructive this was to the child, but also to face the void in her life created by the lack of male affection on a more appropriate level. Near the time of the group's termination, she presented "in summary" all her angry feelings, not only at being put into a segregated group at the clinic but at all the segregation she had experienced in a white society.

The group rapidly replicated the home situation of "mother" domination. The mothers froze the children out, and the children's gripes seemed to rank low on the scale of importance. Much of the therapeutic focus was upon making the children more communicative, for they felt

unable to express themselves within the school setting and ignored at home. Their increasing articulateness in the therapy sessions related to the mothers becoming more attuned to and more accepting of direct, open verbalization.

The heightened awareness of the mothers was evidenced in a session in which the children discussed their dreams. One little girl told of a witch in her dream whom she feared and who kept her huddled in her bed. Her mother immediately broke in with, "I know I'm the witch who's doing that to her." The asthmatic boy told of a dream in which he was frightened because a piece of wood in bed came alive and he didn't know what to do with it. The mothers were aware of how this related to the sexualized relationship of mother and child.

All the children hungered for a father figure, and they gravitated more and more to the male therapist, while the mothers were looking for a mother figure with whom they could discuss their feelings regarding themselves. Thus, we inaugurated separate group play sessions for the children with the male therapist and sessions for the mothers in which they discussed their problems with the female therapist. These sessions were interspersed among the regular group sessions.

In contrast to white, intact family groups, this group brought up many problems of a social nature not subject to solution by psychological understanding and/or manipulation. The group, nevertheless, served as a "forum" where courses of action or even the issue of complaining versus action could be discussed. Problems in the school setting typified those difficulties which were beyond the control of the mothers or the clinic. Such a situation arose when one boy expressed his fearfulness regarding school attendance. Attacking "gangs" whom the authorities could not control, rather than a school phobia, were responsible for his fears. In another school, integration and resultant prejudice on the part of the school personnel was a real, not fantasied, difficulty.

RESULTS AND DISCUSSION

The impact of the group varied from person to person and from family to family. At the end of the year, the boy who wanted to live away from home was the only one who did not wish to continue with the group in the fall. His mother was the worst offender in terms of absence and, realistically, there was little hope of resolving the issues between

them if she was not present in the group. The boy put it very succinctly when he said that he had given up hope of getting what he wanted at home and was gearing his living more and more away from the house to gratify his needs. In the light of the home situation, this was a realistic decision which was a factor in his social and scholastic improvement.

His brother, who was acting out socially, showed no change. He spoke the least of all the children and then only when he chose, which was rarely in response to either therapist or to the urging of the mothers in the group. In view of his attitude and the mother's lack of attendance and unconscious support of his actions, these problems were not susceptible to resolution.

Changes and symptom alleviation in the other families were pronounced. The greatest gain was in the family who attended most regularly. The one girl in the group entered into more positive relationships with her mother and her peers. She and her brother showed marked improvement in their school grades.

The "angry" mother began to break the symbiotic tie to her younger child. This was largely brought about by visits of the other mothers to her home. Their observations, criticisms, and suggestions were brought back into the group, and it became impossible for this woman to continue to deny her behavior.

During the course of the year the obese mother tackled her weight problem, losing over fifty pounds. She abandoned her tentlike coat and dressed very attractively. She made changes in the relationship with her son, offering him more freedom to develop. He attended group regularly with or without his mother, and his grades in school improved. He began to take less of a clown role and to behave more like the other boys in the group.

Two problem areas common with this type of clinic population did not materialize in this group: termination before the achievement of planned-for goals and the necessity for a lengthy educational period before meaningful involvement occurred. The group was effective in involving people in the therapeutic process without the necessity for prior psychological education, and it increased the commitment to mutually planned goals.

What does multifamily group therapy specifically offer with respect to this kind of patient? It provides a continuing source of concrete behavioral examples in place of abstract theoretical concepts. Within the

group setting the role of each member of the family is set forth and can be delineated and interpreted, not only by the therapists but by the members of other families as well. In more traditional modes of treatment, even when interpretations are simple, the concept involved is often difficult to understand. Generally speaking, psychological concepts are a highly abstract body of knowledge. The individual involved in therapy must have either the intellectual capacity or sufficient sophistication to bridge the gap between the abstract concept and the concrete instance to which it is applicable. In multifamily groups, the individual arrives at the concept inductively from the many concrete instances that are apparent in the group setting.

That specific behavioral examples are also taking place in other families enables them to be observed with greater objectivity. The group provides a gestalt for the individual which integrates the behavior of any one person within the family setting and, at the same time, within a wider social grouping. It offers an opportunity for sharing different approaches to living and different familial and social attitudes. And it is an introduction to a more sophisticated approach to the world. Those who had felt it necessary to insulate themselves from what they considered the malicious or deleterious effect of gossip began to appreciate that information, even of a deeply personal nature, can be shared to individual and mutual advantage.

Improvement in communication between families and within the family setting was the most outstanding and consistent finding in all groups. Within families, children were characterized as more articulate, open, and direct. Follow-up indicates that these changes have persisted.

Being sensitive to the needs of a particular population, group, or individual evokes some interesting questions. How neurotic are the needs? What is the therapist playing into by going along with the patient? Is it always possible to discriminate between real and neurotic needs? The answers to these questions are not clear-cut, but it seems to us that the choice lies between remaining rigidly "book-bound," going along only with what is assumed proven, or using one's experience and judgment, knowing full well that some percentage of the decisions made will not prove fruitful. For example, the group's reaching toward a mother figure seemed less related to maneuvering into a safe or comfortable position than to a real developmental lack consequent on all of the mothers having been raised either by grandmothers or in an impersonal institutional

setting. Our accepting this need as bona fide resulted in their greater and more meaningful involvement in the therapeutic process. This also held true for the alternate sessions the male therapist had with the children.

CONCLUSIONS

From our experience with this group and with economically deprived families in other groups, it is evident that attention has to be paid to the hierarchical importance such families set upon therapy in relation to problems of everyday living. That therapy receives a low priority may necessitate foregoing insistence upon a standard therapeutic structure. Rejecting our own rigid adherence to a preferred format or to a rigid definition of what constitutes therapy should lead to fewer rejects in therapy.

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Adolescents in Multiple Family
Group Therapy in a School Setting

VIVIANE G. DURELL

JUNIOR HIGH SCHOOL PRESENTS the young adolescent with a new and often difficult adjustment problem. Many who have managed satisfactorily in elementary school are unable to develop the greater degree of autonomy required of them. In spite of the efforts of the school staff, some students begin a downhill course that continues into high school and results in severe disruption of their secondary school education.

Some sit in class withdrawn and preoccupied. Others become behavior problems, are suspended, fall further and further behind in their work, and get involved in a cycle of increasing misbehavior and academic failure. This may lead to delinquency, court action, and, ultimately, to training school. By the time a student has reached high school, his adjustment pattern may have solidified and useful intervention may have become difficult. Intervention while in junior high school seems to offer the possibility of help before the pupil has progressed to hopelessness.

In the spring of 1963, it was decided to investigate the possibility of assisting junior high school pupils with short-term multiple family group therapy. In work up to that time, the importance of meeting with both parents of the referred student in an effort to achieve a shared family view of the problem and the path to its solution had become apparent. Though the literature contained very little on multiple family group

therapy in schools (Shaw and Wursten, 1965), trial utilization of this technique in several clinical settings (Durell et al., 1965; Lewis and Glasser, 1965; Levin, 1966; Davies et al., 1966) suggested that it combined the advantages of conjoint family therapy (Jackson and Weakland, 1961) with the advantages of group therapy in that a perspective could be gained on intrafamilial problems through observation of other families and through interaction with other family members.

Since current philosophy in the school system did not provide sanction for a long-term therapeutic approach, it was decided to limit the effort to a short-term approach and to restrict the goals accordingly. We defined our purpose as assisting the families in the development of a shared view of the student's difficulty and in the evaluation of a collaborative plan of action. This sort of goal seemed appropriate to "counseling," and that term, rather than "therapy," was used to describe the multiple family group approach.

ESTABLISHMENT OF THE FIRST GROUP

The chief counselor of the selected junior high school, in consultation with the other counselors, compiled a list of 18 problem pupils for whom additional help seemed imperative if they were to derive any benefit from their subsequent education. Most of them had been having marked academic difficulty and many were disciplinary problems as well; several were known to the courts. In general, the families were considered uncooperative. We decided to select only boys of at least average intelligence. The group consisted of four families and was limited to 11 sessions of one and one-half hours each. The chief counselor provided a liaison between the school and the group, a psychologist was the group leader, and the assistant to the supervisor of guidance functioned as an observer and discussed the meetings with the leader in a joint effort to clarify the process. In addition, the latter participated in the meetings as a resource person, an expert on the school system, explaining matters of education, administration, and policy as they became relevant to the group discussion.

The chief counselor contacted each family by telephone and requested their participation in a group being formed. He emphasized the gravity of the boy's problems and the recognition by the school administration that the situation was deteriorating and the boy's education was suffering severely. It was stressed that the group was a trial approach which, it was

hoped, might offer an opportunity for help at a crucial stage in their son's development. The counselor urged each family to attend the first meeting at which time the details would be discussed and they could decide whether they wished to continue. The first four families contacted agreed to come to the first group meeting, and these same families continued for the entire 11 sessions.

DESCRIPTION OF PARTICIPANTS

The First Family

Andre was a 14-year-old eighth grader of average intelligence. He had failed many courses, and his behavior was defiant and insubordinate. He had been suspended from the school many times. His mother appeared depressed and overburdened with family problems. His father spent little time at home because of long hours at work. As in most of the families, communication between the parents was poor.

The Second Family

Sam was a 13-year-old eighth grader whose intelligence was barely in the average range and who had been underachieving since the fourth grade. He was passive and lethargic in class. His mother had expressed strong dissatisfaction with the school to the central office of the Board of Education. She appeared overconcerned and aggressive, whereas the father appeared passive.

The Third Family

George was a 15-year-old who was repeating the eighth grade despite his superior intelligence. Poor academic performance, defiance and truancy were his mode. He was known to the courts and had been placed on probation. His mother was tense and controlling. His father was easygoing and passive and was known to have a problem with alcohol. He was rarely home because he held two jobs.

The Fourth Family

Henry was a 15-year-old ninth grader with average intelligence who had repeated the eighth grade. He was frequently truant or absent with the excuse of illness. He was known to the courts for repeatedly running

away. His mother felt overburdened and ambivalent about her responsibilities. Nevertheless, she frequently made excuses to protect her son or her husband. The latter did not attend the initial meetings because they allegedly conflicted with his work. Subsequently, it was learned that he had not been motivated to attend because he despaired of being useful. He was seen with his wife and son in several special family conferences and his attitude gradually changed.

THE GROUP LEADER'S ROLE

At the outset, the group leader had only a general idea of her role, deciding no more than that she would remain alert to do what she could to facilitate the attainment of the goals originally defined. The role soon developed into an unusually active one. This was evidenced not only in the group meetings themselves but by the fact that over twice as much time was spent in meetings on the "periphery" of the group as in the group meetings themselves. These outside meetings, which usually included the group's resource person, were always aimed at restoring the internal milieu of the group to a homeostasis optimal for the continuation of its task. Sometimes forces operating within the group or within one of the families necessitated these special meetings. At other times, the behavior of one of the boys within the school created a problem. Outside meetings were held with individual families, with individual pupils, and with the group of four pupils. Meetings were also held with individual teachers or a group of teachers involved with the boys, and sometimes one of the boys himself was present. Most important, however, were the meetings with the school administration (principal or assistant principal) and with the chief counselor. The latter played a crucial role in relating the activities within the group to the school and vice versa. He undertook the counseling of the four boys and coordinated communication with the teachers. Though present at only the first and last group meetings, he met with the group leader and resource person before and after each group meeting to report and to be informed. As a result of his involvement, the boys voluntarily sought him out to speak with him on a number of occasions.

It is interesting to consider how the active and complex role of the group leader evolved. Initially, it had been stated to the families that the group leader would not interfere with the school's administrative author-

ity. By the third meeting, however, events led to a modification of this position. Henry had been suspended the day prior to the third meeting and neither he nor his parents attended the session. The leader told the group that she would attempt to establish an understanding with the school administration to treat any disciplinary infraction potentially requiring suspension as a crisis. She then requested that the chief counselor contact her immediately in such a crisis before a disciplinary decision was made so that the matter could be discussed. When it was deemed advisable, the family would be asked to attend a conference immediately. The school would retain its ultimate disciplinary authority, but there would be an opportunity for communication prior to the disciplinary action. The misbehavior of the pupil was conceptualized as unilateral and maladaptive problem-solving behavior, in direct opposition to the expressed goal of the group which was to achieve a shared conceptual base within each family from which to plan mutually agreed upon, effective problem-solving behavior. It was theorized that if the school administration simply responded to misbehavior with unilateral action of its own, feelings would become so intense that the atmosphere of evolving collaboration would be seriously jeopardized. On the other hand, if the crisis was utilized to clarify the problem from each individual's viewpoint, then collaborative efforts to define and solve the problems would be strengthened.

The suspension of Henry was the first crisis and provides a good example of how this policy was implemented. His mother had repeatedly expressed her ambivalence about attending the group during the first two meetings. In a separate meeting with the chief counselor just before the misbehavior that led to his suspension, Henry had said that his mother had told him that she no longer planned to attend the group meetings. She had essentially threatened unilateral action: withdrawal from the group. Immediately after the third session, the chief counselor telephoned Henry's mother informing her of the new arrangement regarding crisis meetings and the importance of her continued participation. He then reported back to the group leader that Henry's mother remained ambivalent. An immediate family conference, including Henry's father, was then held in an effort to encourage the mother's attendance. The family expressed ambivalence during the conference until the group leader stated that, whether or not the parents came, she believed that Henry should continue attending the group meetings. The father then stated that the mother should even run the risk of losing her job so that

she could attend with Henry. Following this meeting, Henry's mother attended regularly. The meetings around this crisis served to facilitate communication within the family, diminish ambivalence, and increase the commitment of the parents.

After this policy toward disciplinary infractions was formed, there was occasional testing behavior, particularly by George and Henry. On the whole, however, there was a marked diminution in misbehavior, and the teachers commented in a conference following the fifth meeting that the boys showed marked improvement in both behavior and academic performance.

EVOLUTION OF THE GROUP

In the early meetings, the parents were prone to place blame upon the school system and the lack of adequate discipline. They expressed ambivalence about the group, doubted that it could do any good, and questioned the qualifications of the group leader. They particularly expressed concern about the usefulness of participating in a group with their sons. By the third and fourth meeting, an atmosphere of mutual trust and increased communication had developed. Wives commented that they had never talked so much with their husbands and that these meetings were forcing them to think. Without engendering defensive responses on the part of their parents, the boys could begin to clarify how their parents' attitudes and responses were contributing to their difficulties. The parents began to recognize how experiences with their own parents had resulted in attitudes which preconditioned their responses to their sons, often in ways which were not useful. By the fifth meeting, the focus had shifted almost entirely to the family relationships, which all considered strongly contributory to their sons' difficulties.

There was evidence of much hostility between the parents, sometimes open and sometimes covert. There was a striking similarity between all four families: the mothers had assumed responsibility for decisions about the boys, while the fathers had withdrawn and were playing largely passive roles in connection with their sons. Though this equilibrium had offered a partial solution to the marital conflict, it was increasingly recognized how this had deprived the boys of necessary interaction with their fathers. The remaining group sessions were not employed to explore further the difficulties in the parental relationships since most of the par-

ticipants felt that this was not an appropriate setting in which to do so. The recognition of the existence of these difficulties, however, and the increased sense of shared responsibility created an atmosphere of mutuality in which the school problems could be discussed more successfully. In several instances, it became possible for fathers to move into closer relationships with their sons and to assist them with problems which had been previously disregarded. This evolution in Henry's family was, interestingly enough, the direct aftermath of another disciplinary crisis. It will be remembered that Henry's earlier misbehavior, which had led to the development of the "crisis policy," had also led to increased commitment by his parents in the sense that his mother afterwards attended the group regularly. His father had not agreed to attend but had stated that his wife should, even if it jeopardized her job. As the group approached termination, Henry promised in the meetings that he would try harder to manage things with the level of support he was obtaining. His behavior, however, became more openly defiant, particularly in his algebra class. In the series of special meetings that followed, it became increasingly clear that he was feeling abandoned and his mother again felt overburdened. It was possible to negotiate increased support and participation from his father and from his teacher and counselor as well, and his subsequent school behavior improved dramatically.

There were marked objective changes in each boy's school performance, and their behavior improved considerably; they seemed happier and more cooperative, and their level of academic achievement rose. The immediate improvement was not completely sustained, however, and the boys regressed somewhat following the cessation of the group meetings. Fortunately, the regression was not complete, and all of the boys did better than would have been anticipated from their performance prior to the group sessions. On several occasions during the succeeding months, the boys requested meetings with us, and these conferences proved quite useful. Perhaps, had the group been continued for a longer period, the gains could have been consolidated and the subsequent regressions prevented.

DISCUSSION AND CONCLUSIONS

By both subjective and objective criteria, the limited goals that had been defined for the group meetings were at least partially attained. In the eleventh meeting, which was devoted to a review and evaluation of

the results, the family members spoke of what had been achieved. They talked of an increased ability to solve problems step by step, increased communication between parents, increased insight, more realistic expectations of their sons, an increased sense of belonging to the community, and an increased understanding of the school's role and the teacher's task. Two families obtained further psychotherapy. The boys spoke of recognizing that they were not "all bad" and that they were in fact trying to live up to their parents' expectations when this seemed at all possible. Moreover, the boys' academic performance and behavior had substantially improved. Though this was not a controlled study, experience with pupils with similar school problems suggests that there would have been a deterioration of adaptation. It would appear, therefore, that the group experience made a substantial difference to the boys and their families.

When the original plans for the group were formulated, a number of members of the school staff expressed considerable doubt about the feasibility of such a group. They did not believe that parents and sons would be willing to communicate freely with each other in a group session, and they doubted that the "uncooperative" parents would even be willing to attend. Our experience demonstrated that this concern was not valid. Each of the four families approached participated. They themselves expressed similar anxieties during the first few meetings, but these were forgotten as the group progressed. In establishing later groups of this type, particularly if the family had undergone previous psychiatric evaluation and treatment with apparently unfavorable results, we found it useful to meet with each family separately before starting the group in order to overcome their initial reluctance. It must be reiterated, however, that the obstacles to open communication were far less than might have been anticipated.

The relationship of the group and the group leader to the school milieu deserves particular emphasis. It must be apparent how different was the group leader's role from that of the traditional group therapist who does not generally interact with the other social systems to which the group members belong. It has become increasingly clear that effective work with problem pupils within the school system, individually or in groups, necessitates intensive work with school personnel, since the pupils, when first seen for counseling, are already involved in negative interactions with the school staff. At crucial stages in the development of the therapeutic process, the pupils reactivate their conflicts with the school.

Unless the school staff's reaction communicates a genuine interest in facilitating efforts at effective problem-solving, the obstacles to progress are immense.[1]

The fact that the multiple family group was established within a school framework may have increased the tendency of the boys to "make noise" in school knowing that it would be "heard" in the family group. Perhaps some pupils are best treated in groups away from the school in order to avoid this complication. On the other hand, those of us familiar with school problems know of many examples of pupils who obtain much individual or group psychotherapy in outpatient settings without the treatment exerting a substantial influence on their school behavior. If it is the school adaptation that is to be influenced, it might best be done in a group arranged so that the interaction between the group and the school culture can be kept under constant scrutiny. It is toward this end that we have been experimenting with approaches such as the one described in this report and more recently have begun to make efforts to influence the entire school milieu of one junior high school.

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[1] Kimbro et al. (1967) have reported on similar multiple family groups conducted at a mental health center with underachieving and delinquent adolescents.

Predicting Behavior from First Impressions of a T-Group Member

PHILIP BRICKMAN

IN RETROSPECT, FIRST IMPRESSIONS often seem highly revealing. Severing-haus and Igersheimer (1964), looking back over the behavior of members of one of their therapy groups, found that the first session had been full of condensed and subtle cues to the members' dominant interpersonal styles. As they noted, the first meeting is open to the expressive efforts of members to structure it in their own images more than will ever again be the case. The authors conceded that these cues may seem mystifying, irrelevant, or unimportant at the time, with their significance only becoming obvious in retrospect. But if these cues are not merely in the eyes of the beholders, there must be conditions under which they are accessible to sensitized observers who do not know how things will turn out. We know that people are capable of predicting some things quite well from first impressions, in particular, whether they will like the other person (Gibb, 1950; Campbell and Yarrow, 1958; Ziller and Behringer, 1961). The question remains as to whether they are capable of predicting the behavior of another person in a situation as complex as a T-group. The present study is an effort to test this.

THE STIMULUS SITUATION

For the stimulus situation, a tape recording of the first meeting of a T-group was selected. There was a wealth of information available about this group, since it was one of four analyzed in detail by Mann (1967).

Subjects were asked to focus on a group member named Peter. In the Mann study of the member-leader relationship, different members were often listed as symbolic leader figures or as targets for the displacement of feelings initially aroused in the group by the leader. In over half the meetings of this group, Peter appeared as a major trainer equivalent, indicating that his relationship with the leader, Dr. Dawes, was central to the group. Along the six dimensions of the member-leader relationship which emerged in the Mann study, Peter scored high on two factors implying, first, an emotional involvement in the member-leader relationship and, second, the acceptance and enactment of leader values (largely psychiatric and psychoanalytic values). With regard to the latter factor, it should be mentioned that Peter was consistently hostile to members of a subgroup who opposed the unstructured, interpretive group atmosphere and called for a more formal agenda, such as lectures by the teacher. Peter's identification with the leader on these points, however, did not prevent him from being hostile to Dr. Dawes. Peter scored high on two factors indicating a very rebellious stance and a preference for counter-dependent flight or withdrawal when dissatisfied rather than dependent complaining. In sum, Peter's relationship with the teacher was highly charged and highly ambivalent, an exaggerated representation of the feelings of the group as a whole.

THE INDUCTION OF SET

It seemed plausible that subjects who attended to the relationships Peter was forming with other people in the group would have a better chance of perceiving the key events of the first meeting and their implications—better, for instance, than subjects who were concentrating on characterizing Peter along various personality dimensions. Also, people may be more accustomed to thinking in terms of social relationships and find this easier and more natural than thinking in terms of personality traits. The social set should encourage subjects to be more empathic in their responses to the target person, while the personality set may invoke more of what is sometimes known as the negative clinical bias.

To test this belief, subjects were divided into two groups. One group received the following instructions designed to have them attend to Peter's developing social relationships:

Social psychologists believe that a very useful way to describe a person is to describe the relationships he forms with other people. To help you listen to Peter, I would like you to think about trying to describe him in terms of the relationships he is forming with other members of the group. In particular, think about describing his relationships with the following three people: Arnold, Dolores, and Dr. Dawes. Each of Peter's speeches will contain a message that is directed to Arnold, a message that is directed to Dolores, and a message that is directed to Dr. Dawes. Your task is to decode these messages as best you can in order to describe Peter by means of these relationships.

The other group received instructions designed to induce them to attend to Peter's personality characteristics.

Personality psychologists believe that a very useful way to describe a person is to describe the traits that are characteristic of him. To help you listen to Peter, I would like you to think about trying to describe him in terms of his personality traits. In particular, think about describing him along the following three dimensions: 1. warm-cold, 2. loyal-rebellious, and 3. anxious-calm. Each of Peter's speeches will contain some information about how warm or cold he is, how loyal or rebellious he is, and how anxious or calm he is. Your task is to use this information as best you can in order to describe Peter by means of these traits.

METHOD

Procedure

A transcript of the tape recording of session one of the T group was prepared and subjects in the experiment were asked to follow the tape with the aid of the transcript. Subjects were informed that the experiment was a straightforward effort to explore how people form impressions.

The Response Measures

After listening to the tape, subjects were asked to fill out a nine page answer booklet. They were allowed to use the transcript for reference while recording their impressions.

To test the predictive accuracy of their impressions, subjects were asked to predict Peter's positions on twenty issues that later came up in group discussions. These issues were selected from summaries of the group meetings over the semester and were listed in their order of occur-

rence. Some of these consisted of statements by Peter expressing senti-
ments that were generally agreed upon in the group; others were state-
ments by Peter that were disagreed with by most of the group; and some
were statements made by others in the group that Peter disagreed with.
Subjects were asked to indicate for each item whether they thought Peter
would agree or disagree with it. These items are reproduced, together
with Peter's responses:

Attitude Prediction Inventory

1. Psychology harms and confuses normal people. (Disagrees.)
2. A beggar is a superior person, independent and free from
common social necessities. (Agrees.)
3. Apathy is repressed and phony; only sharp love and hate are
sincere and true. (Agrees.)
4. The course should be converted into a lecture course by popu-
lar vote of class members. (Disagrees.)
5. The group should be tactful in distinguishing between a per-
son's remarks ("a stupid thing to say") and his personal worth (not "a
stupid person"). (Disagrees.)
6. The group needs to have an appointed leader for each meeting
to guide the discussion. (Disagrees.)
7. People need to act out their hostility in the group before get-
ting down to business. (Agrees.)
8. The teacher should allow himself to be called by his first name.
(Agrees.)
9. The group talks about sex too much, instead of about the
readings. (Disagrees.)
10. The drug mystics have the answers. (Agrees.)
11. The teacher is anxious, dishonest, and manipulative in his
interpretations. (Agrees.)
12. Arnold and others in the group envy Peter's intellectual gifts.
(Agrees.)
13. The group never carries out any of Peter's ideas. (Disagrees.)
14. Love between homosexuals is more passionate than between
opposite sex partners. (Agrees.)
15. The group should talk about its death, at the end of the
summer, when everyone will leave. (Disagrees.)
16. Most of the group's progress through the term has been with-
out insight and hopelessly superficial. (Agrees.)
17. Religious issues (like the question of sin) are relevant to the
group. (Disagrees.)

18. People keep trying to control one another even when they try to become intimate. (Agrees.)

19. The teacher did not care about the group, and the group's progress meant nothing to him. (Disagrees.)

20. Learning to be objective about oneself does not have much purpose. (Disagrees.)

It should be mentioned that none of these items was explicitly discussed during the first meeting. Thus, there was no direct transfer of information from stimulus to test, unlike the case in the Cline-Richards experiments (1960). In those experiments, subjects were exposed to a girl who told them she was president of her sorority, for example, and later they were asked to indicate whether the girl was the kind of person who holds offices in groups. Such questions are more a memory test than a personality judgment. In this experiment there were no items of this sort.

Subjects were also asked to describe Peter's developing relationships with Arnold, Dolores, and Dr. Dawes (questions anticipated by the social set induction), and to describe and rate Peter along the dimensions of warm-cold, loyal-rebellious, and calm-anxious (questions anticipated by the personality set induction). Finally, subjects were asked to rate how attracted they were to Peter and how similar they felt to him.

The Control Groups

In using a structured response measure to test for an experimental effect, there is some danger that the measure itself may induce the predicted responses. Questions may be worded in such a way that there exists a subtle bias toward the "right" answers. Orne (1962) recommends that a special control group also be run, consisting of subjects who are asked to simulate or role-play real subjects. They are not actually exposed to the experimental treatment, but they are told what the treatment is (e.g., being hypnotized) and they are asked to participate as if they had been so exposed, to the best of their ability.

It was decided that such a control group would be appropriate in the present experiment. Controls were given the same instructions as experimental subjects and asked to fill out the same answer forms for their impressions, but they were not allowed to listen to the tape or read the transcript. They were thus given a kind of structured projective test for

what they thought a person named Peter would be like. If the experimental groups are accurate, but no more accurate than the controls, it will be apparent that such accuracy did not come from listening to the tape.

Subjects

Subjects in the experiment were 52 students enrolled in an introductory psychology course at the University of Michigan. There were 11 subjects in each of the control groups (hereafter abbreviated CP and CS, respectively) and 15 in each of the experimental groups (hereafter abbreviated EP and ES). Subjects were randomly assigned to the social or personality set treatments.

RESULTS

The Prediction of Attitudes

The experimental groups proved to be more accurate than the controls. In the experimental groups, an average of 55.4 per cent of subjects were correct on each item, versus 47.6 per cent per item in the control groups. This difference is significant at the .05 level, with a t of 2.15.

The major contribution to the difference comes from the improvement of the ES group over the CS group, not improvement of the EP group over its CP controls. The CS group averaged only 43.2 per cent correct (with chance being 50 per cent), while the ES group got up to 54.9 per cent correct. The CP group averaged 53.6 per cent correct, while the EP group reached 56.0 per cent. This impression is confirmed if the groups are considered separately by set. A Wilcoxen test indicates that the ES people did better than the CS ones at the .01 level (z of 2.61), while the same test does not show a significant difference between the EP and CP groups (z of 0.52).

On the Attitude Prediction Inventory, there was a considerable degree of consensus even in the control groups, in which, on the average, two-thirds of the subjects answered each item the same way. If only those items on which there is near-unanimity in a group are scored (items on which at least 80 per cent of the group agreed), however, we find more consensus in the experimental groups. In the CP group there were three such consensual items; in the CS group there were five; in the EP group,

seven; and in the ES group, twelve. The increase in the number of high-consensus items following exposure to the tape was significant at the .01 level.

Subjective Reactions

Subjects given the social set reacted more favorably to Peter on all dimensions, as can be seen in Table 1. The effects of set were significant

TABLE 1

Perceptions of Peter on Five Dimensions by Different Groups

	Dimension				
Group	Perceived Warmth	Perceived Loyalty	Perceived Calmness	Liking	Perceived Similarity
CP	4.18	1.50	1.09	2.95	2.09
CS	4.27	2.85	3.82	4.36	3.18
EP	4.10	2.13	2.60	3.37	3.57
ES	4.97	2.54	3.13	4.60	3.67

at the .01 level on the calm-anxious scale, the loyal-rebellious scale, and the rating of attraction. Set was significant at the .10 level on warm-cold. On similarity, the effect of set was in the right direction but was not statistically significant.

Experimental condition had a significant effect on only one dimension: subjects' perceived similarity to Peter. Subjects in the experimental groups rated themselves as more similar to Peter than did the controls.

There is a significant interaction effect on the calm-anxious scale. Subjects in the EP group saw Peter as less anxious than subjects in the CP group, while the ES group saw him as more anxious than the CS group. The net effect of this interaction was to bring the social and personality set groups closer together in the experimental condition. A similar interaction (though falling short of significance) is discernible on the warm-cold and the loyal-rebellious dimensions. Also found was a general reduction in the extremeness of ratings of Peter in the experimental groups. Thus, over-all, the experimental groups differed from the controls in two ways: they perceived themselves as more similar to Peter, and they gave less polarized ratings to him. This suggests the interesting hypothesis that there is a relationship between perceiving a target person as bland and perceiving him as similar to oneself.

DISCUSSION

What information was gained by the experimental groups that enabled them to predict better on this inventory? Why did the CS group do so poorly and the CP group relatively well? Some tentative answers to these questions may be gleaned from an inspection of individual items (listed in the Attitude Prediction Inventory).

Although the items were selected on the basis of their salience to the history of the group rather than their content, it seems possible to separate the items into several classes on the basis of their content. One cluster of items seems to refer to a personality factor that might be called rebelliousness or scorn. Items in this cluster have potential shock value; they are often very negative. Some are general opinion statements that indicate a rejection of middle-class values (items 2, 3, 10, 14). Others are statements that seem to indicate scorn for others in the group (11, 16).

Another group of items seems to refer mainly to T-group culture or T-group norms. Some of these refer to general values (1, 20). Others imply rules of procedure (4, 6) or rules of relevance (9, 17). Though these items tend to differ from the dominant values of middle-class culture, they do not have the shock value of the items in the first cluster and are usually the subject of general agreement within T-groups.

These two clusters (hereafter labeled A and B, respectively) were validated by three independent sorters, each working from the written criteria specified above. Items on which there was disagreement among raters as to proper placement were not included in either cluster.

The experimental treatment did not significantly improve performance on any of the items in Cluster A. The experimental groups averaged 0.6 per cent better on these items than the controls. On Cluster B, however, there was a significant improvement from listening to the tape. On these items the experimental groups averaged 16.2 per cent better than the controls. Mean change on three of the items taken separately (1, 6 and 20) was significant at the .01 level, and mean change on the others approached significance.

This effect seems to make some theoretical sense. On the items in Cluster A, Peter offered opinions sharply at variance with those of the group majority. In Cluster B, Peter's positions coincided with the group's opinion. Subjects evidently succeeded in perceiving the Peter who acted as spokesman for certain T-group values, not the Peter who served as

group hero and group antagonist. They seemed to be using what they were learning about T-groups from the tape recording to predict views for Peter. This interpretation receives some additional support from what happened on another item (15) concerning the group's agenda (hence falling into Cluster B). It happens that on this item Peter's position was at variance with the group's position—and on this item, subjects in the experimental groups tended to be less accurate than the controls.

The explanation of why the CS group did so poorly and the CP group so well probably lies in the fact that accuracy on a number of items (particularly in Cluster A) involved a willingness to attribute some highly negative or at least highly controversial views to the target person. Subjects with a more negative view of Peter should be more willing to perceive him as holding such views. As detailed in Table 1, the personality set people held a much more negative view of Peter. This contributed to their achieving what must be called a spurious accuracy on this test. The social set people, on the other hand, had to obtain enough information from the tape on other, group-related items sufficient to overcome their inaccurate bias on the controversial items.

It is interesting to speculate about precisely what in the different instructions made the difference. Did the social set increase favorability, or did the personality set decrease it? If it was the personality set, for instance, that was the active factor, was the effect due to the induction of personality-trait set in general or was it due to the specific choice of adjective pairs used as examples in the present experiment? The latter of these questions cannot be answered without further study, but there is some evidence that bears on the former. Other investigators have reported that subjects bring a positivity bias with them to first-impression experiments (DeSoto and Kuethe, 1959; Matkom, 1963; Zajonc and Burnstein, 1965). Given no information about the target person at all, subjects will tend to rate him positively rather than negatively. These results, particularly those of Matkom, imply that it was not the social set creating a positive bias but rather the personality set inducing a negative bias.

SUMMARY

To explore the predictive accuracy of first impressions, subjects (N = 30) used the tape recording of the first meeting of a T-group to predict

the attitudes on future group issues of one member (Peter). As compared
to an Orne-type control group (N = 26), experimental Ss were somewhat
more successful in predicting Peter's attitudes, mainly on items on which
Peter agreed with the group majority. Experimental Ss were less extreme
in their ratings of Peter, showed more agreement than controls, and felt
more similar to Peter. Ss within each group who were told to attend to
Peter's personality traits (personality set) were less favorable to him than
Ss who were told to attend to his developing social relationships (social
set).

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Group Therapy with Young Psychotic Children

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IT IS GENERALLY CONCEDED that the treatment of young psychotic children is difficult, frustrating, and anxiety provoking. It is difficult because much of the material which the patients bring, verbally or through their play, is highly symbolic and can be understood, if at all, only after months of patient observation. When and if understood, the latent content falls outside the usual analytic scheme of reference, is not only pregenital but preoral, and is therefore difficult to interpret. It is frustrating because the therapist's reward, the patient's improvement, is limited and very slow to appear. The primitiveness of the conflicts and the brutality of the emotions are certainly a source of anxiety to most therapists.

In order to observe psychotic children in therapy and to learn more about their psychopathology, we developed a group approach to the treatment of this difficult type of patient. To subject our group method to a crucial test, we used it to treat a group of psychotic children without speech. The prognosis is very poor, according to Kanner and Eisenberg (1955), when there has been no speech development before age four. We were interested to see if, in the absence of speech, conflicts would be expressed through symbolic play.

Anthony (1958) has proposed that autism is not a deviation from

normal development but a fixation at a very primitive preoral level. Thus, we were equally anxious to observe the behavior of these children for the insight it might give us into the feelings and behavior of infants.

From previous work by the senior author (Gratton, 1962; Gratton et al., 1966), we formulated the following postulates:

1. Psychotic children might interact in the group situation in ways that showed some of their conflicts.

2. Although without speech, these patients might still communicate some of their conflicts through symbolic play. Their symbolic play would be on a very primitive level and very difficult to understand.

3. Since withdrawal is a symptom shown by most young psychotic children, a group situation would have the advantage of making flight into isolation very difficult, if not impossible.

4. If no play material is provided, the members of the group might become objects of interactions.

The aim of this study was to test these assumptions.

PROCEDURE

Sample

In 1963-1964, there were a number of extremely psychotic children in the Inpatient Unit of the Ellen Steinberg Department of Child Psychiatry at the Jewish Hospital of St. Louis. The sickest patients were selected for the experiment. Criteria of selection were the severity of the illness and lack of speech.

The group was started with six patients, one of whom was on day care in the unit. After a month, two patients had to be discharged. Three patients were added to the group, making a total of seven patients, and the composition of the group then remained stable.

The group was composed of five boys and two girls. Their ages ranged from four to seven years. The socioeconomic origin was professional (medical and law) in three cases, managerial in two, small private business in one, and low civil service in one case. All the families were intact.

In terms of diagnostic category, four patients were labeled as primary infantile autism, using Kanner's criteria (1944), and three as childhood schizophrenia. The diagnosis was made by staff and consultant psychiatrists, independently of us. Our own diagnoses were in agreement. Only one patient had some degree of speech; the others had either not

developed speech or had lost any speech acquired. All the autistic children had been disturbed practically since birth, and the schizophrenic children had been psychotic for at least two years. All had normal electro-encephalograms, and none showed any positive neurological signs. Three patients had been in the hospital for more than a year; the rest had been admitted a few months before the beginning of this study.

All of the patients except one were in individual therapy before the experiment, and these therapies were continued. This factor makes it impossible to draw any conclusions as to the effectiveness of group therapy with these children, but the aim of the project was not to evaluate group therapy.

Technique

The patients were seen in a small room (9′ x 12′), bare except for chairs and permanent shelves on the wall. Those children who had transitional objects[1] were allowed to keep them. Otherwise, no play material was permitted in the therapy room.

Three therapists participated in the group, the two authors and a kindergarten teacher. From previous experience with a similar group (Gratton et al., 1966), we felt that the patients' therapeutic needs could not be met by a single therapist.

The technique used has been described elsewhere (Gratton et al., 1966). The therapists were essentially nondirective and did not require the children to play or engage in any activity. However, in this group, we were much more active than in previous groups: we stimulated the patients more, in terms of contact and sensorimotor functions. Our work has similarities with what Goldfarb (1965) has described as "corrective socialization." The technique is original, but Anthony (1963) and Speers and Lansing (1965) have done similar work.

After the first month and a half of the experiment, during which the patients were seen three times a week, the frequency of the group sessions was increased to five times a week. This rate remained constant for nine and a half months. Then, since hospital budgetary factors did not permit us to keep on with this group for more than a year, in the last

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[1] A transitional object is an inanimate object, invested with libido, to which the child is addicted and on which the child depends when the mother is not around. The object is usually cuddly and soft and is a symbol of the mother's warmth. It is transitional because it is intermediate between reality and pure fantasy.

month sessions were tapered off to two a week. Each session lasted from half an hour to an hour, depending on the tolerance of the patients and the therapists.

Only three parents were seen regularly at weekly intervals, since most lived at a distance from the hospital.

Collection of Data

After each session, pertinent data from our observations were written down, and every week an extensive summary of the five sessions was dictated. The patients' progress, or lack of progress, was rated according to a three-factorial scale developed by the authors. Throughout the year, parts of the sessions were filmed in color on a random schedule.

RESULTS AND DISCUSSION

The data obtained can be best considered under two headings: the content of the sessions and the interactional or group processes.

Content

An outstanding feature of this group was the apparent lack of conflictual material. These children were out of developmental step with the rest of the world, and they did not seem to care as long as they were left alone. But as they could not very well remain alone indefinitely in the group, their conflicts eventually began to emerge.

The main observable conflict was their lack of human involvement and fear of human contact, along with their often exclusive preoccupation with inanimate things and their own bodies. This was collective material, i.e., a conflict brought into therapy by all patients. Some patients became very anxious when we merely looked at them, and any physical contact made them quite panicky. There was a psychological distance that the patients maintained, and they became highly anxious and showed an avoidance reaction when it was invaded. With these patients, we felt that we had to penetrate this barrier even at the risk of a panic reaction. They first became interested in what we were doing to them (our actions, e.g., a pat on the head), then in inanimate things connected to us (keys, shoes, clothes), later in parts of ourselves as fragmented and independent objects (hands, mouth, etc.) and finally in us as complete persons.

This was not true of all of the patients, however. Some had apparently evolved a defense against anxiety by becoming completely indifferent, by shutting off the world completely. They did not show any reaction whatsoever, not even resistance, to human physical contact. It was like dealing with inanimate objects. This denial of the outside world and the efficiency of the barrier to outside stimulation (Bergman and Escalona, 1949; Goldfarb, 1965) was at times amazing and seemed to be biological as well as psychological. In some cases, there was no startle response after a sudden loud noise, no blinking response when an object came abruptly close to the eyes, no sound or avoidance movement and no change in expression when hit by another child. Some children stayed motionless, practically in a catatonic state, despite an amount of stimulation that would have sent another child running away screaming.

The patients demonstrated convincingly that they were in contact with reality, most of the time at least, in the group situation. But responses to what they perceived were absent or so distorted that they did not seem to be connected with the situation at hand. For example, whenever we approached any patient, one child would run screaming to the shelves and climb on them to isolate himself; he was apparently aware of what we were doing to the other patients since he reacted the same way when we tried to approach him. Whenever a patient would attack us, all the patients would become very quiet and watch intently and anxiously. Their responses were mostly odd, often unintelligible, but were apparently often in reaction to what was happening around them.

Most of these children were extremely immature from a developmental standpoint. When accepting outside stimulation, they reacted to it like infants six to 18 months of age. Indeed, much of their behavior would have been quite appropriate for infants of this age. They made cooing sounds, reacted to stimulation with their whole bodies, and seemed to like to be held in the therapists' arms. Early in the group history, primitive social games were observed, such as making something appear and disappear, etc. The mouth was very important for perception, as well as the rest of the head. Hand-mouth movements, as described by Spitz (1959) in babies, were often seen in these children. Some anxiety was aroused at times by their failure to communicate their needs or by some change in routine, but otherwise the children behaved pretty much like contented infants.

Very few of these patients were mature enough to convey their conflicts through symbolic play. One patient who showed obsessive interest in holes and cavities in the walls eventually extended this interest to the therapists' body orifices and cavities: eyes, ears, nose, and especially the mouth. He forced our mouths open and peered inside with much interest. Eventually, a few months later, he gingerly and fearfully felt our teeth with his fingers. Two months later, he turned this exploration into a game and put his arm, elbow, or hand into our mouths, but he reacted with anxiety if we softly closed our teeth on his arm. This play was tentatively interpreted as indicating a fear of being bitten or eaten.

A child who had an obsessive interest in shoes and socks developed a ritual around removing the shoes and socks from other children. He tied the shoelaces together to make a long string of shoes which he pulled after him. His interest was undoubtedly fetishistic, as it was accompanied by much sexual stimulation and masturbation. The latent meaning of this play never became clear to us.

Another member of the group, a boy of seven, had a repetitive symbolic play which consisted of urinating on the floor and then sitting down to make clapping sounds on the wet floor with his hands. During this play, he kept anxiously repeating "glasses." The sound produced was that of a child being spanked directly on the skin. We tentatively clarified this play as his fear of being spanked, and further elaborated, "Daddy is spanking you." A check on the history of the patient confirmed that his father wore glasses and had repeatedly abused the child physically. In answer to our interpretations, the child first laughed anxiously, later spanked himself, and a few months later spanked the therapist. This symbolic play has now stopped, and the child appears less fearful.

EVOLUTION OF THE GROUP AND GROUP PROCESSES

The group started out not being a group. The patients were withdrawn and isolated entities and put as much distance as possible between themselves. In the early stages, it was more individual therapy in a group setting than group psychotherapy. There were only minimal and sporadic interactions with the staff, and avoidance reactions usually followed any approach that we made.

Resistance became intense after three weeks, and it was difficult to round up the patients and bring them into the therapy room. Their entrance was chaotic, with some climbing on the shelves to isolate themselves from the group. Group anxiety was high; panic reactions were common occurrences and sometimes forced us to take patients out of the group.

By the second month, most patients passively accepted brief contacts from the therapists and did not try to avoid us. This acceptance might have been helped by physical illness and the resulting need to be mothered in that most patients had contracted influenza. They were a little less isolated in the group and rarely used the wall shelves to escape the group situation. There occurred occasional interactions between pairs of patients, developing eventually into sadomasochistic coupling. The children became less resistant and readily came to therapy, but the anxiety level was still very high.

Starting with the third month of therapy, the group looked more organized, and their spatial distribution in the room was centered around the therapists. Some tried to contact other children, usually in odd ways, e.g., touching with their chin or head, mouthing and smelling, banging head against head, etc. Some became engaged in autoerotic activities; others showed fetishistic interest in shoes, socks, hair, etc. The room was actively explored.

In the fourth month, the therapists became the object of their explorations. We were investigated in every conceivable way: we were smelled, licked, mouthed, poked, and bitten. Our ears, nose, mouth and teeth were of special interest. They were also interested in our clothes. The first, and about only, sentence we heard from a small girl was, "Take your pants off." They came to us for support when anxious, fearful, or hurt. They watched us a great deal, and at times there was an expression of discontent when other children came to us.

Rivalry developed further and became more intense during the fifth month. The patients competed for attention and reacted with anger and aggression when they had to share a therapist with another child. Attempts at play were slightly more adequate, and sometimes two patients played together and exchanged things. The patients were not only tolerating each other but were often searching each other out without too much anxiety. They were more in contact and were paying attention to what was happening in the group.

After six months of therapy, frustrated by the therapists who could not, and did not try to, give any one child their exclusive individual attention, the children invested more and more in one another. One patient abandoned her transitional object for the first time, another lost his fetishistic interest in shoes, and both interacted more with other patients. Group cohesion became marked, and there was a gradual decrease in rivalry. The patients came running to the therapy room when the therapists appeared on the ward. Whenever we were late, they were waiting for us, and they became very upset when a session had to be canceled. Their facial expressions changed a great deal, as can be seen in our film (Rizzo and Gratton, 1965). Their dull, expressionless, lifeless look was replaced by a more intent and lively expression, often punctuated by a smile.

CONCLUSIONS

This experiment in group therapy with psychotic children has demonstrated the validity of our hypothesis that the patients would show their problems in the group situation. Although at first very few conflicts were apparent, their fear of human contact and their disturbed capacity to relate became obvious through their withdrawal, lack of involvement with people, exclusive preoccupation with inanimate objects, and their unresponsiveness or panic when approached. Their immaturity, making much of their behavior similar to that of infants, was remarkable.

Their immaturity and their lack of involvement did not entice them to communicate their conflicts through symbolic play, as less severely psychotic children do (Gratton et al., 1966). The lack of verbal communication remained unchanged.

Withdrawal became impossible in the group after a few weeks. Apparently, autism is at least a partly reversible state, since the patients became progressively more involved with the therapists and with each other. Group processes appeared slowly and group cohesion developed after six months of therapy, as though in a slow-motion film.

There was a slight improvement to be seen in the patients, but its slow rate of appearance would suggest that four or five years of therapy would be needed to bring these children to a neurotic or near-normal level of functioning, if, that is, they can ever be brought to such a level at all.

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The Influence of Unstructured and Structured Group Psychotherapy with Geriatric Patients on Their Decision to Leave the Hospital

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Iᴛ ɪs ɪɴᴄʀᴇᴀsɪɴɢʟʏ ᴜʀɢᴇɴᴛ that careful consideration be given to the problem of long-term geriatric patients who no longer need the psychiatric services of the state hospital but, having lost contact with the outside world, resent the idea of moving out of what they consider their "home." The present research was an attempt to assist a group of geriatric patients at Pontiac State Hospital to make the decision to leave the hospital and to prepare them for a successful adjustment in nursing homes, preferably in the communities from which they had come.

Based on the underlying assumption that the behavior of the aged has the potential to change, an experiment was designed to discover whether or not group therapy could be used to persuade institutionalized geriatric patients to agree to move and whether using directive or nondirective modes of therapy made any difference.

METHOD

Eighteen male and 18 female patients from four geriatric wards were selected for the study. These were patients who no longer required psychiatric hospitalization but had steadfastly resisted previous attempts at outside placement. The average age of the subjects was 70, and the average length of hospitalization was approximately 20 years. Clinically, 23 of these patients had been diagnosed upon admission as schizophrenic, six as involutional psychotic reaction, five as chronic brain syndrome, and two as psychopathic personality. However, the diagnostic label of the patients was of minor importance. An attempt was made to equate the two experimental groups for sex, age, and length of hospitalization. In the absence of an additional comparable group of patients, it was decided to regard the participating subjects as their own controls as far as their decision to leave the hospital was concerned. This was justified on the grounds that earlier attempts to move them out of the hospital had been resisted and no other attempt to change their minds except the mentioned therapy was instituted.

Weekly behavioral evaluations were recorded by a team of judges from the nursing staff. The instrument used was a rating scale developed by psychologists at Pontiac State Hospital which included the following dimensions: anxiety, affective display, socialization, work attitude, and appearance. Each item was rated on a scale of 1 to 9, with "1" being an absence of symptoms and "9" being symptoms present in their most severe form. Since, in the category of affective display, pathology might have manifested itself in two directions, i.e., "too much" or "too little," the effects were rated on double subscales: (a) affective display exaggerated, (b) affective display diminished. Values of 1 to 9 were used as mentioned above. The same method of double subscales was used in socialization and appearance scales. In addition, a sociometric questionnaire was devised and administered before and after therapy in which participants were asked to name individuals from the experimental groups with whom they preferred to interact in various social situations.

Two group psychotherapy approaches were employed as a means of influencing the patients' attitudes toward the goal of accepting placement outside of the hospital: Group A, unstructured group, and Group B, structured group. A male psychiatrist and a female psychologist acted as

therapists of both groups. Each group met twice a week for a period of twelve weeks. Each session lasted at least an hour. The unstructured approach was a typical nondirective group therapy method, whereas the techniques used with the structured group roughly corresponded to the operant conditioning procedures advocated by current learning theories. In the structured therapy situation the sessions were preconceived and well ordered. There was no such planning in the "unstructured" approach, and the group was permitted to proceed as the members wished.

The two groups differed in the following characteristics:

Choice of Topics to Discuss

The main characteristic of the structured group was the fact that the therapists manipulated and controlled the conversation, concentrating on the problem of leaving the hospital, whereas everything was up to the group members in the unstructured situation. If the therapists decided to discuss a topic which was rather threatening to the patients, the structured group did not have a chance to escape it. Each individual could be asked direct questions and attempts to change the subject would fail. Thus, they developed the habit of listening to or talking about things which gave them ambivalent feelings.

In the unstructured group, if the group did not feel comfortable enough to develop certain topics and preferred to change the subject, the therapists did not pursue the topic. Similar subjects were brought up and discussed in both groups, but the initiating sources were different in the two approaches; while the therapists directed the conversation in one situation, the participating members chose their own topics in the other.

Reinforcement of Particular Kinds of Statements

The structured group was positively reinforced with approval for statements about being independent, making one's own decisions, leaving the hospital, returning to the community, and so on, while the unstructured group was not thus reinforced. A more or less neutral attitude was adopted in the unstructured group, leaving the responsibility of the value judgment to the individual expressing the opinion. Statements in favor of community life, about being independent, and so forth were neither enthusiastically encouraged nor deliberately discouraged.

Choice of Whether or Not to Visit Outside the Hospital

In order to give patients a chance to familiarize themselves with the "world outside" which they had rejected, bus rides, visits to nursing homes, and various other activities were scheduled on Sunday afternoons. All subjects in the structured group were expected to participate in these trips unless they had a serious excuse. The unstructured group was free of such pressures; the members were always welcome to join the group if they wanted to, but they did not have to do so if they preferred not to.

RESULTS

Therapy had a beneficial effect on the patients' deciding to leave the hospital. A total of 27 patients from both therapy groups expressed a wish to leave the institution at the end of the treatment period. This number represented 75 per cent of the entire group of subjects in the study. This percentage was significant at the .05 level, indicating that results were not due to chance factors. There was no statistically significant difference in decision to leave due to the different methods involved. Ten patients out of 17 in the unstructured group and 17 out of 19 patients in the structured group stated they wanted to leave the hospital at the termination of therapy. A chi-square test between the number of patients in the two therapy groups who expressed their willingness to move to a nursing home at the end of the treatment period did not reach statistical significance. What difference there was favored the structured therapy.

The effect of therapy on scale judgments for each group on each ward for each scale separately were analyzed by an analysis of variance

TABLE 1

The Unstructured Group

| | Hospitalization | | | | |
| | Less than 20 years | | More than 20 years | | |
	Male	Female	Male	Female	Total
Age Below 70	2	2	2	2	8
Age Above 70	3	3	2	3	11
Male	5		4		9
Female		5		5	10

TABLE 2
The Structured Group

| | Hospitalization | | | | | |
| | Less than 20 years | | | More than 20 years | | |
	Male	Female		Male	Female	Total
Age Below 70	2	3		3	2	10
Age Above 70	3	2		2	2	9
Male	5			5		10
Female		5			4	9

design for proportionate data with unequal number of observations. The method of fitting constants was selected and the Abbreviated Doolittle procedure was used on data taken from the rating scales. Using four groups (unstructured therapy, less than 20 years of hospitalization; unstructured therapy, more than 20 years of hospitalization; structured therapy, less than 20 years of hospitalization; structured therapy, more than 20 years of hospitalization) no changes were found in rated behavior which were considered significant.

While not included in the analysis of variance, the effects of sex and age were examined through the use of graphs. Certain sex differences were observed, the men responding to therapy better than the women and better to structured therapy than to unstructured. The effect of age was not clear. The absence of significant change with therapy was not a function of the scale's lack of reliability. The median reliability for this instrument was .74. Therefore, it seems likely that substantial behavioral changes did not occur for the total group.

The socialization of the group as a whole was assessed by a sociometric technique. The results of a t-test for significance of the difference between the mean number of names mentioned on the two applications of the instrument yielded a value significant at the .001 level. The two therapy groups did not differ significantly in mean increase in number of names. These analyses provided evidence to show that even though the clinical behavior of most patients did not significantly change after exposure to varying types of therapy atmospheres, their experiences in the group situation increased the number of acceptable social partners. If nothing else, at least the regular afternoon "coffee hours" contributed to a socialization process.

A follow-up investigation, carried out a year after the completion of the original study, showed that 17 patients had left the hospital. This figure corresponded to 51.5 per cent of the number of possible candidates for placement at the end of the treatment period. It should be noted that a female patient died during the initial stages of the project, and two other female patients had been considered unfit for placement; they had to be dropped from the program because one developed a serious physical illness and the family of the second one, objecting strongly to the idea of placement, had secured an agreement from the administration to exclude the patient from the study. Of those who had moved to nursing homes, eight belonged to the unstructured group and nine to the structured group. None of them have returned to the hospital so far, and reports from social agencies have indicated that they have made successful adjustments.

It would have been desirable to provide openings for all of those individuals who wanted to leave the hospital at the termination of the study. Even though the majority of the 17 patients left the institution within three months after the cessation of therapy, some had to wait longer depending on the availability of beds in nursing homes and the zeal of social agencies in placing these patients.

Regardless of the practical difficulties involved, the fact that 17 patients from both therapy groups have left the hospital and have been doing well in the "outside world" should be at least a fair indication of the effectiveness of therapy programs with geriatric patients.

SUMMARY

The present study was undertaken to encourage a group of institutionalized geriatric patients to decide to leave the hospital wards and move into nursing homes in their home counties. They were subjects who had persistently refused such placement in the past. Unstructured and structured therapy approaches were employed.

Analyses of the data indicate that neither the unstructured nor the structured group psychotherapy methods significantly altered the rated behavior of the patients. However, there were some significant positive relationships between desirable behavioral changes and decision to leave the hospital. Even though there were many more subjects in the structured group who decided to leave the institution compared to the num-

ber of patients in the unstructured group who made the same decision, the difference was not statistically significant. Changes on a sociometric questionnaire indicated a highly significant improvement in choice behavior between patients. However, the two therapy groups did not differ significantly in improvement on this criterion. Seventeen patients left the hospital within a year, eight from the unstructured group and nine from the structured group; none has returned.

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The Effect of Observers on the Process of Group Therapy

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A survey of the literature reveals contrasting views as to whether the presence of observers inhibits the group process and interferes with treatment. Goforth et al. (1966) align themselves with those clinicians who feel that the presence of observers inhibits group spontaneity and patient interaction, thus resulting in antitherapeutic effects. Berne (1966) states that therapy is inhibited by observers, various types of recording apparatus, and even by the presence of a co-therapist. Although conceding that research in psychotherapy is needed, Berne regards research and therapeutic goals as antithetical.

Berne and Goforth may be concerned with the complex issues of confidentiality and trust, which are said to be compromised when there is more than one therapist (co-therapy), more than one patient (group therapy) and still further when there are observers present, particularly if they are hidden from view.

In contrast to the views of Berne and Goforth, Powdermaker and Frank (1953) report that if the therapists themselves are not inhibited by the presence of observers, if the group is prepared in advance and has a clear understanding of the role of the observers, then there is no inhibition of psychotherapy. Experimental support for this position was supplied by their research in which it was demonstrated that observers

not only did not inhibit the group interaction but that spontaneity was actually facilitated by the presence of observers. Kadis et al. (1963), while reporting no research findings, made similar observations based on clinical experience. Nash and Stone (1951) and Bernardez (1968) demonstrated the value to the therapist of utilizing an observer to note patient-therapist behavior which might otherwise go unrecognized by the therapist. Illing (1962) observed that group interaction is catalyzed by the presence of guards in a prison group therapy program. Erickson (1966) reported both inhibiting and facilitating effects on therapy when movies were taken of individual sessions; upon reviewing the films, however, he concluded that the presence of observers and apparatus did not interfere with the conduct of therapy.

Unfortunately, much of the literature on the effect of observers is clouded by the failure to define the role and status of the observer, his physical location in the group, and whether or not he was expected to participate in the group process. Loefler (1954), Lementani (1960), and Gans (1957) call a silent co-therapist an "observer." Berne seats "observers" within the group circle, rather than apart. Block (1961) discusses the differential effects on group interaction when the "observers" are silent, are active co-therapists, or are transcribers. Krasner et al. (1964) discuss some of the problems entailed when the silent observer has difficulty in remaining silent. Sternberg et al. (1958), in a consideration of effective ways of studying and understanding psychotherapy, suggest that the therapist has more difficulty in adapting to a movie camera, which is often perceived as an observer, than do the patients. Bergman (1966) has stated that patients, in contrast to therapists, freely accept any proposed "unusual features," whether these be microphones, tape recorders, apparatus for recording physiological changes, or the presence of observers. Bergman gives examples of his own resistances as well as those of other therapists. Redlich and Dollard (1950-51) note that when explanations are given to patients that recordings take the place of note-taking and that confidentiality will be strictly observed, negative reactions are fleeting unless reinforced by the therapist's own doubts about the procedure.

While we do not presume to resolve the controversy, a review of three years of experience with nonparticipating observers in an ongoing psychoanalytic therapy group may shed some additional light on this important issue.

METHOD

To test the hypothesis that observers do not inhibit psychoanalytic group therapy, observers were introduced early into a group of adult outpatients. The group was told at the third meeting that students who were in training in psychotherapy would be observing the group and that the therapists knew of no reason why the presence of observers should detract from the group's therapeutic goal. The group was also told that if, for some reason the authors could not anticipate at the time, it became apparent that therapy did suffer, the observers would be discontinued. In so doing, it was communicated to the group members that the therapeutic goals of the group were primary and that training considerations were secondary. Patients were encouraged to verbalize whatever thoughts, feelings, or fantasies they had about the observers. In practice, whenever a patient did so, these were explored by means of such questions as: "What comes to mind about it?" or "Toward whom have you felt that way before?" or "What does that remind you of?"

The observers sat in chairs set apart from the table around which the patients were seated. The observers were instructed to be silent, not to interact with group members, and not to take notes.

The therapy group was originally composed of seven members, five women and two men between the ages of 21 and 35; basically character neurotics, they had been selected for having high motivation for long-range change and the capacity to benefit from intensive psychoanalytic group psychotherapy. Patients were screened out who might require individual sessions, medication, or hospitalization. The therapists were peer, male-female co-therapists with a similar theoretical orientation and comparable experience as psychotherapists. The group has been in existence for three years and includes several new members who replaced original members who dropped out at different times for different reasons.

RESULTS

The initial reaction of the group was one of apparent passive compliance; no patient said that he could not talk under such circumstances, and there was no apparent increase in anxiety or hostility. The group wanted to know more about the people who would observe and were told that they were trainees and professional people in various disciplines:

medical students, psychology interns, psychiatric residents, and social workers. The group appeared to adopt a wait-and-see attitude. They did not know when the observers would first appear. In the four succeeding therapy sessions, there was no apparent change in the level of resistance in the group.

After the seventh session, when the observers first appeared, passive compliance gave way to various other reactions. These included hostility toward the observers and the therapists, feelings of resentment, fears of criticism, and feelings of being rejected. The patients felt angry toward the observers, but they were also angry when the observers missed sessions. The patients complained of the observers' youth, inexperience, lack of interest, and about the way they stared at the patients. Some felt that the observers were critical, judgmental, and not accepting of their psychopathology. They expressed the feeling that the observers were only interested in them as cases and specimens to be studied and laughed at.

The following are examples of specific reactions to the observers:

On the first day that the observers were present, a female patient stated that she did not feel free to talk about her personal problems in front of strangers. However, following interpretation of this as a defensive maneuver against revealing herself to the group and to the therapists, this patient began to discuss highly personal and ordinarily embarrassing material, namely, an affair she was having while separated from her husband, a current pregnancy from this affair, and her search for a criminal abortion. This example suggests that a patient's statement that he or she cannot talk about personal problems "with strangers present" should not be taken at face value but should be interpreted as resistance. On later occasions, when other patients manifested similar behavior, group members would point out the resistance with comparable results.

One patient was critical of the observers' irregular attendance and felt that they should be present regularly or not come at all. This patient's desire to have the therapists set firm limits against irregular attendance by either the observers or the group members was explored and was found to relate to traumatic childhood experiences of being repeatedly abandoned by her mother. As a child, the patient had been placed in several foster homes, boarding schools, and in the homes of unwilling relatives. Just when she was becoming adjusted to one of these placements, her mother would return and take her to live with her for a few months and the cycle would be repeated. This example demonstrates a transference

reaction to observers which, when interpreted as such and explored, led to significant historical material and expression of repressed feelings.

Early in therapy, one patient wondered what the observers thought about the patients in the group, saying she felt they probably laughed at them, thought them "nuts, sick with serious problems." She then spontaneously commented that these feelings were similar to her family's opinion of her and was the way in which they viewed her symptoms. She related that her mother had told her that her problems were "deep-seated" and had made fun of her attending the therapy group. This example illustrates how internalized superego attitudes may be projected upon observers. Elaboration demonstrated the defenses of projection and displacement. Insight into the patient's mechanism of reinforcing her low self-esteem allowed modification of it, and she eventually left therapy with increased self-confidence and a realistic estimate of her capabilities.

A single, attractive woman of 35 complained that she felt uncomfortable because of the observers and was particularly annoyed with one medical student who stared at her during an entire session. When asked whether there were other occasions when she felt stared at by males, she replied that it happened all the time and she had wondered why she attracted such attention and why she felt so uncomfortable about it. During the group discussion, it emerged that she did not give herself enough credit for being an attractive woman and that she was unconsciously seductive but felt that this was wrong. She was confronted with having a defensive, prudish attitude. Later explorations revealed that this patient had a severe sense of inadequacy stemming largely from a competitive relationship with her mother in which the mother successfully undermined her attractiveness and her sexuality.

The group learned from experiences such as this that reactions to the observers were almost always unrealistic but were useful to explore because of their revelation of transference feelings. They also learned that there were unconscious resistances to revelation of transference feelings, and they grew accustomed to challenging assertions by patients that their feelings were based on the reality of the observer situation.

On another occasion, the same patient was angry about the presence of observers and felt that her privacy was being invaded since she believed that one observer was from her neighborhood. She announced that she would not reveal any details of her personal life to "a student and a man." Another member confronted this patient with the observation that,

of late, even when no observers were present, she had not been candid with the group and had rarely discussed her own problems. Following this, the patient discussed a dream in which members of the group were prying into her life. Associations led to a discussion of her feeling that the leaders and the group members were treating her unfairly in regarding her as prudish. She vigorously defended her moral standards, stating that, "Men expect women to be virgins when they marry." She then revealed her anger at men, who "aren't worth the powder to blow them to hell." Such feelings were spontaneously related to long-standing fears of men as "big bad wolves." This reaction had elements of both transference and resistance. Further exploration led to considerable uncovering of repressed feelings.

On one occasion, when a medical student did not return as an observer, the group accused one of the female members of traumatizing the student by an angry attack on him. At the time, no exploration of this was made by the therapists. However, later in therapy it became clear that this patient was very competitive with the other members, was resentful of any new member in the group, and was prone to make dynamically correct, but premature, interpretations. One such "wild" interpretation had been instrumental in the discontinuation of treatment by a new male member whose seductiveness had threatened her.

Her attitude toward one medical student-observer was an early indication of what was to become a significant aspect of the interpersonal behavior of this patient in the group. This patient's use of "wild interpretations" to keep other people at a distance, take the focus off herself, and express her hostility and competitiveness had ramifications in terms of her sibling rivalry, heterosexual fears, and the need to avoid looking into her own motives.

One medical student was described by a male patient as "a creep." He stated that he would never seek out such a physician as his personal doctor because "you can just tell that you couldn't have much confidence in a person like that." This patient was very resistant in the group, rarely discussed his own problems, and initiated meetings and interactions with group members outside the therapy hours.

In the early stages of therapy, it seemed "safer" for patients to express transference feelings about the observers than about the therapists. In this instance, interpretation of the displacement was not made because it was not appreciated at the time by the therapists, and this omission may

well have contributed to the patient's terminating therapy prematurely. The authors feel that this patient's termination was not because of the observers but because the therapists failed to explore the negative transference.

A young male patient became very angry because of the presence of observers and demanded to know whether the therapist was going to keep his promise to remove the observers if they interfered with therapy. Encouraged to verbalize his feelings and thoughts about the observers, he revealed a fantasy that the observers and the group were part of an experiment: the patients were guinea pigs, the room was bugged, and the therapists were only interested in a book they were writing. Exploration led to revelation of intensely hostile-dependent transference feelings. The patient was angry because one of the therapists had recently gone on vacation, and he felt that the therapist did not care what happened to him. This transference reaction turned out to be a repetition of early childhood feelings that his parents did not care about him since they often left him alone and unsupervised.

The reaction of patients that they are being treated like guinea pigs can only be explored and clarified as transference when it truly is unrealistic. The therapists' primary goal must be the therapy of the patients, and the therapists must know themselves sufficiently well not to be unwittingly fooling themselves on this score.

One member was absent from the group following the announcement that observers would be present in the future. Upon her return, she verbalized feelings of inadequacy and stated that she could not talk in front of the observers because medical students were intelligent and would make her feel "stupid." This led to her discussing feelings of being unattractive, intellectually inferior to members of the group, and unable to understand "the big words" used by one of the other female members. Further associations led to her sharing with the group childhood experiences of academic and social failure and an inability to compete with a brighter, more attractive older sister.

This displacement of transference feelings from group members onto the observers is similar to displacement from the therapist onto the observers. Direct expression may be too frightening because of unconscious expectations of retaliation. The observers are "safer" transference objects because of the reality that they do not talk back. This example again illustrates that exploration of reactions to the observers as mani-

festations of resistance and transference can lead to the uncovering of significant historical content and repressed feelings.

SUMMARY

Experience with this therapy group supports the position that the presence of observers does not interfere with or inhibit the therapeutic process. The examples demonstrate that reactions to observers are examples of resistance and transference. If these reactions are explored in the same fashion as are any other such manifestations in therapy, they can be effectively worked through, resulting in therapeutic change. It is our observation that the same depth and freedom of expression occurred in this group with observers as in similar groups without observers. We feel that the presence of observers, which is important for training and research, is not incompatible with the goal of therapeutic change for the patients.

Therapy is not inhibited by the presence of observers if: (1) the primary goal of the therapists is the welfare of the patients; (2) the therapists are not inhibited or uncomfortable because of the presence of observers (this may come with experience and increased feelings of adequacy as a therapist); (3) the therapists are not in conflict with the observers; (4) the group is prepared for the presence of observers by being given a realistic explanation of their role and status; (5) the permission of the group has been obtained; (6) free association concerning thoughts and feelings about the observers is encouraged; (7) reactions to the observers are treated as is any other manifestation of resistance and transference; and (8) the role of the observers is clarified by their sitting apart from the group and being silent.

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A Nontherapeutic Device for Approaching Therapy in an Institutional Setting

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KELMAN (1963) HAS WRITTEN THAT "psychotherapy can be regarded as a social influence situation in which the patient's relationship to the therapist is the primary vehicle for the production of therapeutic change." The present report provides a description, justification, and pilot evaluation of a technique for dealing with patients in an institutional setting who lack the requisite interaction skills for participating in a "social influence situation" and who are therefore unable to enter into a patient-therapist relationship. Where there is such a lack, as with severely withdrawn schizophrenics, prognosis is poor and treatment tends to become simply custodial. If it is possible to find a way of introducing such patients to interaction skills through nontherapeutic means, a gate to psychotherapy may be opened.

Our working hypothesis is that *a nontherapeutic use of group processes in an institutional setting may be an essential step in the introduction of certain patients to the more formal procedures of therapy.*

FUNCTIONS OF INTERACTION

Social interaction serves a number of important functions and has a variety of results for participants. For example, groups can provide expressive formats for individuals and may present viable contexts within

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which processes of influence and reference can develop. This has been one emphasis of group therapists (Scheidlinger, 1952; Stock and Thelen, 1958; Cartwright and Zander, 1960). More generally, participation in a group can also provide opportunities for learning social skills (Bach, 1954). We can say that an individual has developed or is in a position to develop generalized interaction skills if he shows sensitivity to the constraints, opportunities, and shared meanings that define a social reality, if he is able to contribute to the maintenance and movement of his group, and if he can detect and use the feedback of information pertinent to his conduct. These capacities are variable, but we assume that there is a simple minimum which is sufficient to bridge the gap between sheer withdrawal and the types of behavior necessary for the initiation of therapy.

THE PROBLEM

With this as a general background, we shall describe the use of a particular group technique in an institutional setting with subjects who were severely regressed and generally unresponsive. Because the conditions of application and assessment were far from ideal, the report will be of interest more for its description of the device than for the findings.

One important aim of the group worker in an institution is to provide patients with a viable and restricted social constellation in which appropriate responses may take place from the outset. The development of socially responsive and socially adaptive behavior in such a context requires first that there be some visible and salient group goals. These can, in turn, provide a base for the operation of those pressures and opportunities which are the source of social learning. This means that the group must be structured so that participation is necessary and sufficient for the individual members to be rewarded. Since our control is generally limited in these situations to the task system, it is there that we must begin, assuming only that patients can learn what the emerging pressures mean and that they may then become amenable to more conventional therapeutic routines which require some sort of coherent social response.

There are often imposing limits to the success of a program. Some are practical, having to do with time constraints, space deficiencies, schedules, and lack of personnel. Some involve the methodological difficulties of defining and establishing group goals and managing the participation of patients. Still others relate to the nature of the patient's illness and its

amenability to treatment of any sort. Severely regressed patients are rarely brought into a position to participate, even on an elementary level, in social relationships, and consequently are rarely able to learn how to adapt socially. They are often assigned, under a prognosis of continued deterioration, to a ward with the recommendation of continued confinement and constant surveillance. The occasional foray into the realm of activity is ordinarily individuating and trivial, having none of the properties necessary for social learning, and, in fact, it often trains a kind of incapacity. The patients rarely respond to therapeutic advances by doctors or to social advances by group workers, nurses, or other patients.

We attempted to place some severely withdrawn and regressed patients in a simple but meaningful social environment in order more fully to explore the implications of these considerations. Five characteristics of the situation were thought to be essential:

1. The medium of social exchange and the currency should be non-threatening. This means that the character and quality of the goal is itself at issue. Face-to-face interaction using a familiar language and dealing with symbols, imagery, and gestures of the sort that appear in ordinary commerce would not, for the severely disturbed patient, constitute a viable social reality. Familiar tasks and problems are similarly defective. It is presumably under just such circumstances that anxiety, fear, and debilitating associations are active. That these patients do not respond to ordinary social advances and therapeutic efforts may be a reflection of the medium in which they take place.

2. The task must be simple in terms of the requirements for social coordination. It must permit a meaningful reward or the completion of a significant cycle of activity while preserving its essential simplicity. Since typical extrinsic rewards such as money, tokens, or some other form of extra gain are associated with the social reality within which the individual is unable to function, new goals and activities must be found.

3. The situation must require that each participant take account of the behavior of all the others in working toward a group goal. The importance of the goal and the fact that it requires cooperative effort within a relatively nonthreatening milieu are the major features which permit social learning to occur.

4. The activity itself must be intrinsically attractive or have critical elements which are attractive. Performance itself should be appealing

and valuable to the person in terms of its provision for a sense of accomplishment, involvement, and reward.

5. The procedure should be efficient in terms of staff and equipment, and it should be capable of being mounted on the spur of the moment.

To meet these requirements in a coordinated fashion is difficult. Group techniques usually operate in a threatening medium which requires, in addition, skills at time-binding and bargaining. The patient is not easily able to see a valuable end in sight. Goal-orientation is inhibited, and the integration of effort and concern essential for the effectiveness of the procedure is impaired.

We have worked with a simple device which seems to meet the conditions listed above. A special kind of musical ensemble was established in which the very existence of the group as well as the value of its products depended on participation, coordination, and the individual's responsiveness to the activities of others. Whatever its other potentialities in an institutional setting, music seems to provide a relatively unfamiliar and attractive medium for interaction, and when the skills required for the production of a melody are not individual musical skills, defensiveness seems to be at a minimum.

Subjects were given flutes each of which produced only a single note. Because the instruments were simple in construction, it was only necessary to blow through one end in order to produce sound. Each flute carried one and only one pitch. Altogether, they represented the diatonic scale. If there are enough participants, and if the melody (the group goal) is one which is both attractive and technically feasible, and if the particular melodies chosen permit the participation of all or most subjects, then most of the above requirements will have been met. The resultant interaction, though mediated by an institutional agent as leader, requires cooperation, takes place in a sufficiently unfamiliar and therefore relatively nonthreatening medium (which is nevertheless not totally foreign), presents the subjects with a meaningful result in a reasonable length of time, takes place within a context which, for most subjects, is intrinsically attractive without that attraction being derived from some previously untenable situation, requires a minimum of staff effort, and uses inexpensive equipment.

In passing, it is possible to argue that the key to the success of this procedure is the leader and that the result is simply the establishment of dyadic relationships between each individual and the leader. If this is so,

then there still is good reason to regard the technique with favor. It would mean that the participant is capable of working toward a goal with some degree of coordination even though that coordination depends on instructions. Nevertheless, observation suggests that a culture is established under these conditions and that individuals act toward each other as members of a group moving toward a group goal. There are orienting responses, criticisms, and acknowledgments of success. Furthermore, as will be seen, some extension beyond the confines of the group is in evidence.

PROCEDURE

There are three basic steps to the procedure. First is recruitment of participants. This is followed by instruction and arrangement of the ensemble, a delicate ad hoc period of socialization. Finally, there is the performance itself, including terminal appraisal. There are several sessions, each involving the three steps despite some carry-over of culture from session to session.

The flutes, which were precision-made bamboo flutes costing $3.00 each and blown through their ends like recorders, were shown to patients on the ward. They were approached individually and asked, "Would you like to try the flute and help us play melodies?" Those who agreed to participate (in whatever form) were given the instruments and taken to the area where the group was being assembled.

The patients were encouraged to try the instruments individually and to experiment with them. They were told that, "The flutes play only one note by themselves; you can produce melodies by joining the group and playing with it at the proper time." That time was determined by a signal given by the supervisor. When the group was assembled, the instructions were repeated and the patients were reminded that, "It requires the cooperation and proper response of all members of the group in order to achieve music, in order to play a melody." The participants were then arranged in the order of the pitch of their flutes, from the lowest tone to the highest.

Melodies were selected primarily on the basis of familiarity and were taken from the volume, *Folk Songs for Everyone*, published by the Remick Music Corporation, New York. Examples of the selections were: "Pop Goes the Weasel," "To Work Upon the Railway," "Here We Come

Awassailing," and "John Peel." From session to session, some participants requested different songs, an indication that goals were established and attractive. Later, it became possible to use melodies in which all or most of the tones were used ("Betsy from Pike," "Frankie and Johnny," etc.). The performance system included many of the items of interaction usually found in group process analysis. There were criticism and support, orienting requests and demands, and evaluations of action and its results. That these became relatively normative suggests that a rudimentary culture emerged both within sessions and to some extent across sessions.

OBSERVATIONS

Most of the patients accepted the flutes at each session. There were a few instances of initial negativism and resistance, but these dissolved when the individual actually held the flute and blew into it. Only twice during the five sessions did a patient in the group appear nervous about his performance. One left almost immediately, but the other stayed and participated. For the latter, it was the first time that he had become involved in any organized activity on the ward.

Most members were concerned with their own performance rather than with that of the others. They had to rely on others, but they did not seem willing to acknowledge this through action. The fourth session was the best from the point of view of group product. During that session, performance was apparently facilitated by the presence of a patient who praised the group effort. Members became mutually oriented and began to criticize and praise each other. It was as if the responsive audience, even though it was only one patient, served to remind the participants that they were a group.

There is some indication that beyond the development of simple social skills suited to the particular situation, there was some generalization and extension to other activities. Three of the subjects who had never before participated in ward activities of a social nature joined in a ball-throwing game. Another showed a more dramatic change. He had been sitting on a chair looking straight ahead when the supervisor suggested that he try the flute. He refused, saying that, "It came from the hated Japs and I will have nothing to do with it." After discussion, he was convinced that the instrument was not harmful, and he finally joined the group. After

a session, he was reported to have taken part in a baseball game in which he "hit a single."

CONCLUSIONS

The technique described in this paper suggests interesting directions for research no less than for therapy. We have reason to believe that the medium and goal introduced an opportunity for subjects to engage in what was for most of them unusual social action. Under these conditions it is possible that some learning took place so that the effects were more than simply situational.

In the area of retardation, this kind of procedure might be useful not only as a stimulant to the development of social skills but also as a way of teaching manual and occupational skills. The learning of certain skills rhythmically and in the context of group controls might be more fruitful than the more fragmented experiences ordinarily provided during the course of training and rehabilitation. Social forces provide a density which may enhance certain kinds of learning.

For research in group dynamics, most studies using group goals have either left the goal extrinsic to the activities of the group and its participants or constructed goals which were divisible for the members. When a group goal has been given status, it has been overly simple and lacked a compelling and therefore integrating quality (cf. Cartwright and Zander, 1960). The studies have not, in other words, presented a clear goal nor one which "mobilizes energies of group members behind group activities" (ibid, p. 345). This paper describes a simple manipulation which presents a clear goal which is neither trivial nor divisible. Utilizing it in an experimental setting would permit the study of conflict with respect to choice of goals, conflict between individual and group goals, patterns of coordination and the like.

We do not intend to argue that music has some uniquely rewarding properties that make it suitable for pretherapeutic use. But for most subjects musical performance is not a familiar sphere of action, and associations to it are not within the types of experience which may have conditioned their present state. It may be that initial interaction is easier to obtain in concrete, nonverbal forms than in verbal forms.

It is of course possible that the observed effects were either due to observer bias or to the attention lavished on these patients by care which

was different from that usually present on the ward. If the procedure allowed even that perception, however, it might be considered successful, although not distinctively so.

SUMMARY

Single-tone flutes were distributed to severely regressed, institutionalized schizophrenic patients. In order to achieve a recognizable melody, cooperation was essential. Through performance and interaction in a relatively unfamiliar and nonthreatening medium, social behavior was exhibited and in some cases extended to new situations. It is argued that this nontherapeutic device could serve to aid in the development of minimal social skills for later participation in the processes of psychotherapy and that it meets a number of criteria thought to be critical for the efficacy of such a technique.

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Book Reviews

Edited by

IRVING A. GOLDBERG, Ph.D.

GROUP THERAPY IN CHILDHOOD PSYCHOSIS. By *Rex W. Speers* and *Cornelius Lansing*. Chapel Hill, N. C.: University of North Carolina Press, 1965, 186 pp., $6.00.

Group psychotherapy considers itself to be a useful therapeutic instrument which does not have to defend itself as a technique pure and simple. It lends itself to experimental usages and practices not thought to be suitable in other modalities. The writers of this report utilized group therapy techniques to study and to treat psychotic children. Regardless of their theoretical formulations about childhood psychosis, their work stands as a pioneering effort that can offer hope to workers with psychotic children, especially in a day hospital or on an outpatient basis. In essence, the Speers-Lansing group treated, over a four-year period, preschool, psychotic children and their families by a total program which centered on group therapy as the major technique, but not by far the only one.

They originally worked with five children, four of whom they classified as having symbiotic psychosis and the fifth as Kannerian autism. The parents, who were in different types of group therapy, presented uniformly serious personality deviations.

Throughout the work of the four years reported here, the staff maintained a flexibility of approach. They used desensitization, conditioning, tactile education, physical restraints, education, verbalizations, and other devices in the group situation with the children. The mothers' group met along more customary lines, although they were in a combined parents' group in the third year and in a finger-painting group. The children later were in arts and crafts, in therapy jointly with their mothers, and also in individual therapy.

In such a treatment situation with so many variables involved, to single out any one procedure as overwhelmingly important might be considered presumptuous. But it seems to ring throughout that the staff, including the many paraprofessionals who shared the work, thought and acted in a group-oriented manner, so that the group as a core kept them united, goal-oriented, and focused. That in itself offers insight into a use of group therapy in childhood psychosis.

The results were good, with four children entering kindergarten after eighteen months. The authors describe other positive results. Some of their observations, such as the countertransferences of the staff, play up the usually ignored factors of staff emotions in such a massive treatment enterprise. They detail how ". . . the behavior of the individual child became understandable in terms of the unconscious wishes of his mother" and how "it was repeatedly demonstrated that the children's behavior altered only after the unconscious fantasy in the mother was verbalized and interpreted."

The authors adhered to Anthony's idea of the group ego. They used the therapeutic symbiosis of the group to supplant the pathological attachment to the mother. Whether the reader accepts their formulations in that framework is perhaps secondary to the basic statement the work makes: group therapy, used flexibly and creatively, has definite, positive values in the care of psychotic children.

IRVIN A. KRAFT, M.D.
Houston, Texas

GROUP COUNSELING AND PSYCHOTHERAPY WITH ADOLES-
CENTS. By *Beryce W. MacLennan* and *Naomi Felsenfeld.* New York:
Columbia University Press, 1968, 198 pp., $6.00.

This is a much-needed book, the first devoted exclusively to working with adolescents in small groups. Its organization permits a broad treatment of the subject, moving as it does from such general issues as "The Group as an Agent of Change," "The Adolescent and His Culture," and "General Considerations in Group Counseling and Psychotherapy," to more specific questions of "Process and Maneuvers in Adolescent Groups" and "Major Themes in Adolescent Groups." The final two chapters deal with "Groups in Different Settings" and "The Group Leader and His Training."

The authors set an almost impossible task for themselves: to produce a book which would "serve as an aid in program development and conceptualization" as well as "a basic text for those interested in learning group methods." As to the book's intended audience, it was designed for both "professionals and sub-professionals who are working with either normal or emotionally disturbed youth." This work is a formidable undertaking when one considers the complexity of adolescence in its normal and pathological facets, the difficulty in distinguishing between various levels of group intervention (i.e., counseling and psychotherapy) and the problem of devising a single training aide for both professional and nonprofessional workers. While the authors might understandably have fallen short of their stated aims, they have nonetheless produced a sound and comprehensive guide (if not a basic text) for all those engaged in working with adolescents, whether individually or in groups.

An outstanding contribution is made by those parts of the book which deal with the adolescent's interaction with his environment and more generally with the role of our social systems in socialization and rehabilitation. Of equal excellence are the conceptualizations of planful interventions to promote a change in adolescent behavior through the utilization of group dynamics. Furthermore, the lucid differentiation between various public and private programs serving adolescents, as well as the extensive bibliography, should be invaluable as resource data.

A problem is created for this reviewer by what appears to be a shortchanging of "depth" psychology and clinical psychopathology. When the authors "for purposes of simplification" decide to discuss simultaneously the techniques of intervention appropriate for *both* socialization and therapy groups, the roles of counselor and therapist are blurred and considerable confusion is the result. The fact that most groups for adolescents nowadays are not aimed at "deep-seated character reconstruction" does not mean that clinicians working with such groups should not have the fullest possible understanding of intrapsychic conflict. Yet, in this book, which purports also to deal with psychotherapy, these latter aspects are handled in an overly superficial manner, as is the whole subject of unconscious motivations and their genetic origins. Is it desirable to use such terms as defense, transference, resistance, or Bion's "basic assumptions" without a full and clear discussion of the nature of these concepts? Or of their differential applicability in the work of the group counselor and the analytic group psychotherapist?

The above questions about some limitations of this book as a text for training group psychotherapists should not be taken to mean that professionals working with adolescents will not find it useful. In fact, it should

prove indispensable to clinicians involved in community mental health programs. For educators, group and recreational workers, and for all those nonprofessionals engaged with youth, this volume is a "must."

SAUL SCHEIDLINGER, Ph.D.
New York, New York

THE BIRTH OF THE EGO: A NUCLEAR HYPOTHESIS. By *Edward Glover*. New York: International Universities Press, 1968, 125 pp., $3.50.

This small volume is a review, critique, and expansion of Glover's previous communications on ego development and in particular on his theory of "ego nuclei" and a "primary functional phase" of development published from 1929 to 1949. Glover contrasts and compares his views with those of Hartmann, whom, along with Klein and others, he refers to as "neo-Freudian." He disparages such concepts and terms as "autonomous ego cores," "inborn ego apparatuses," "preconscious autonomisms," etc. Part of this work amounts to a *tour de force* in favor of a reconsideration of developments in modern ego psychology since "The Ego and the Id." He deplores the lack of clinical data or basis for Hartmann's attempt to construct a comprehensive psychology. Glover supports his own views by attempts to integrate and update his earlier works, especially those on the classification of mental disorders, which constitute his own clinical grounds for the theory of "ego nuclei" and a "primary functional phase" in nuclear ego formation. The latter term, introduced in 1949, is admittedly mainly devised to oppose trends elsewhere to conceptualize an integrated or synthesized ego structure in the earliest stages of life. There seem to be no solid substantive additions to his previous writings on the subject, and the essay appears to be unnecessarily rambling, repetitive, ponderous, and at times contentious.

There is no gainsaying Glover's sophisticated comprehension of psychoanalytic theory and technique, but he has managed to compose a difficult and tedious essay. Also, one feels that his posture here is that of a very bright, erudite, "old-time" conservative denouncing the new orthodoxy in ego psychology and plumping for his own respected but comparatively infertile theory which he identifies as more truly Freudian. It is the kind of work which yields greater clarity and occasional rich historical perspective from a second reading. The clearest and most immediately rewarding sections are in the introductory chapter, the chapter on

ego synthesis, and the one on the relationship of theory to practice. There are two appendices in which he summarizes his criticisms of Hartmann's hypotheses and explores the possible technical utility of his own. Most of Glover's pertinent earlier papers upon which the present monograph is based are collected in the volume, *On the Early Development of the Mind*, and they are a useful reference for anyone wishing to follow the details of this difficult new work.

GEORGE H. ALLISON, M.D.
Seattle, Washington

PRACTICAL PSYCHOTHERAPEUTIC TECHNIQUES. By *Calvert Stein*. Springfield, Ill.: Charles C Thomas, 1968, 191 pp., $7.50.

In the preface of this book, Dr. Stein indicates that he proposes to present the five major techniques of psychotherapy, which are designated as psychoanalysis, psychoanalytically oriented psychotherapy, group psychotherapy, psychodrama, and hypnotherapy, in a single work. It is not clear, however, for whom this work is intended as he refers only vaguely to the needs of psychotherapists and students.

The contents include definitions of concepts, references to the history and major contributions in the field of psychotherapy, and descriptions of specific activities of the therapist. Brief excerpts from actual interviews and case histories are used for illustration. Despite his initial emphasis on the presentation of five techniques, the author's organization of the work is in four parts. These are (1) psychoanalysis and psychoanalytically oriented psychotherapy; (2) group psychotherapy and psychodrama; (3) hypnosis, hypnotherapy, hypnodrama, and hypnoplasty; (4) drugs and psychotherapy. The techniques of group psychotherapy, psychodrama, and hypnotherapy are explained for application by the reader, while information about psychoanalysis and psychoanalytically oriented psychotherapy is used as a background. The chapter on drugs seems to be a brief tour of some adjuncts to psychotherapy which do not fit into the other categories. Hypnotherapy receives the primary emphasis as a technique, with subheadings of preparation of patients for hypnotherapy, hypnotic induction, and management of the trance state. The intimate conversational style of the book is reminiscent of that found in guidebooks which include a smattering of practical advice.

The failures of this book are many, with the inadequacies in content, style, and organization perhaps being due to major lack of clarity in the

purpose of the writing. It would be hard to determine to whom this volume would be useful. The background information given is too superficial to be of use to the thoughtful clinician, no new concepts are explicated, and it is unsettling to think that therapists would undertake such procedures as hypnotherapy from a manual. ". . . the dearth of authoritative presentations of the five major psychotherapeutic techniques within the covers of a single volume" is not remedied by Dr. Stein.

<div align="right">BEVERLY S. MacKENZIE, A.C.S.W.
Portland, Oregon</div>

PROJECTIVE TESTING AND PSYCHOANALYSIS. By *Roy Schafer*. New York: International Universities Press, 1967, 220 pp., $5.50.

Roy Schafer is well known in the field of clinical psychology and psychodiagnostic testing for such works as the *Clinical Application of Psychological Tests* and *Psychoanalytic Interpretation of Rorschach Testing*. In those volumes he presented useful insights by applying a psychoanalytic frame of reference to the behavior samples elicited from patients in a testing situation. In this third and most recent volume, while continuing to show the application of analytic personality theory toward understanding behavior, Dr. Schafer in addition conveys a somewhat subtle, but nonetheless important, message related to the experimental validation of the process of psychoanalysis or psychotherapy. This is an approach which includes countless hours of test battery administration, interpretation, and work-up done on many individual patients rather than the more usually chosen (and easier) task of evaluation of objective test data with fairly large numbers of subjects. If the clinical researchers who complain about the kinds of research done on psychotherapy, outcome, and process were to read this volume, it might be of benefit to them.

This book suffers to some extent in its organization, as must be expected in a book made up of a number of papers written at different times and for different occasions. There is also inevitable repetition, which Dr. Schafer recognizes. However, the effect of the repetition is minimized by the way in which the points are approached and expanded, and serves to drive home very clearly the way in which the author thinks and operates as a clinical professional. The organization of papers presented in the book is primarily chronological; another order might have made the reading easier without so many shifts of set.

Seven of the nine chapters in this book are very clear. The ideas,

concepts, and intent are carefully presented and easy to follow by any reader with an average knowledge of psychoanalytic theory and psychological testing. Two chapters are somewhat fuzzier and assume advanced knowledge on the part of the reader. These are the last two chapters in the book, which revolve around discussion of body-ego disturbance and perceiving and acting in psychological test responses.

Of particular interest to beginning psychologists are chapters on transference in the patient's reaction to the tester and on the psychoanalytic study of retest results. The first of these should help novice psychologists recognize some of the ways in which they as human beings and as professional persons may affect the results that they obtain in the testing situation. The second chapter indicates how the qualitative use of retests may be approached and utilized. This is in contrast to the quantitative approach so often used which sometimes masks or covers up subtle but nonetheless significant personality changes.

From the examples of clinical test material, the reader may find himself suggesting alternative hypotheses and asking different questions than those posed by Dr. Schafer. Thus, one will again be struck with the subjectivity of the material with which we psychologists deal when we engage ourselves with projective techniques.

Projective Testing and Psychoanalysis again illustrates that Dr. Schafer is one of the few clinical psychologists who dedicate much time and arduous effort to the process of psychodiagnosis and one of the even fewer number who is willing to communicate his efforts, thoughts, and work for the benefit of others outside the circle of his patients or colleagues.

CARL E. MORGAN, Ph.D.
Portland, Oregon

ADVANCED TECHNIQUES OF HYPNOSIS AND THERAPY: SELECTED PAPERS OF MILTON H. ERICKSON, M.D. Edited by *Jay Haley*. New York: Grune & Stratton, 1967, 557 pp., $14.75.

This is a book which is long overdue. Milton H. Erickson is not only the foremost modern exponent of the scientific use of hypnosis and the man to whom we are most indebted for its current acceptance, but one of the foremost tacticians of psychotherapy. A number of his papers, published in journals through the years, have been gathered together here to provide some idea of the scope and magnitude of his contributions. Whether one's interest be in hypnosis itself, in hypnotherapy or psycho-

therapy, in the science of behavior, or in an acquaintance with one of the most original and stimulating minds of our time, this book deserves careful reading.

The book begins with a foreword by Lawrence Kubie and a biographical account of Erickson's life by the editor. Erickson's papers are divided into three sections dealing with techniques of trance induction, experimentation with hypnosis, and techniques of therapy. A bibliography lists his publications from 1929 through the time of the publication of this volume in 1967. The book closes with an appreciation of the significance of his contributions to hypnosis and therapy by Dr. Haley, and an index.

Erickson's point of view regarding hypnotic induction calls for informal and permissive inductions. His general viewpoint on hypnosis is set forth in two papers, while a transcript of a trance induction with subsequent commentary provides a demonstration of this viewpoint in action. Among other modern techniques of hypnotic induction invented by Erickson are the hand levitation method, the "surprise" and "my-friend-John" methods, and the confusion technique. These are all described in detail.

The material covered in the section on experimentation ranges from studies of amnesia and posthypnotic behavior to studies of the unconscious as it operates in the psychopathology of everyday life, to the ability of one individual in a dissociated state to interpret correctly productions by another person in a similarly dissociated state even though these are not interpretable by either in normal consciousness. The effects and authenticity of hypnotically induced deafness, as well as experiments with color vision and color blindness, are considered. One extremely interesting paper recounts a series of experiments with and on Aldous Huxley comparing hypnotically induced states with states achieved by meditation.

Those interested in symbolism or in the unconscious will find the case studies in the section on psychotherapy of inestimable value. Special procedures and strategies for dealing with therapeutic problems are discussed directly and indirectly by example in dealing with the case material presented. Issues of concern to every therapist are constantly raised, and new possibilities for dealing with them presented. Dr. Erickson is an explorer of new ground, and reading his explorations should stimulate any therapist to new and unhackneyed approaches to the problems with which he is dealing.

This book is exciting. It is not for those who adhere to the tried and

true. For those who realize that dealing with people is an adventure, it offers techniques and approaches to actualize that adventure.

BERNARD S. AARONSON, Ph.D.
Princeton, New Jersey

PROGRESS AND REVOLUTION. By *Robert Waelder*. New York: International Universities Press, 1967, 372 pp., $7.00.

In this, the last published book of the late Robert Waelder, some of the best psychological interpretation of historical and political material that has yet appeared in print is presented. Writing in a field which has not developed a set of standard analytical tools, an author must necessarily rely greatly upon his personal judgment. This necessity increases the complexity and difficulty of presenting a sound and meaningful position. Individual political opinion also challenges a writer when his desire is to develop a view based on reason and worthy of the criterion of objectivity. Other obstacles to succeeding in Waelder's chosen task might be cited. Despite all of them, the result presented in this volume has achieved a very high measure of success. Breadth of perspective, objectivity, erudition, and insightfulness are the marks of this book. And in all of the emotionally charged material that is discussed, one would be hard-pressed to catch Waelder grinding an ax even a single time. He just does not seem to bear a grudge for anyone. And this is not to say that he agrees with everyone. He does not. But he tries to bring light to his discussion, not heat.

The content of the book is heavily weighted in favor of substantive discussion as opposed to methodological issues. And the subject is primarily contemporary social and political issues in the light of world history. Earlier history is discussed when it illuminates Waelder's subjects, which include man's innovation and utilization of science and technology and also the changes of man and society through revolution. It is readily granted that science makes progress. And the nature of this progress from the earliest times is discussed, as is its impact in a modern world which shares unevenly in the benefits of science. Whether man himself progresses is another question. Men often claim that they do, but this is a most complex question which is too often settled by hope and preconception or, shall we say, bias. Waelder recalls the anecdote of the governess who is told to see what the children are doing and have them stop it. This is the conservative bias. The counterpart of this tale illustrates the liberal

bias: having the governess see what the children are doing and help them do it. Such preconceptions are avoided by Waelder. And this helps him to deal with issues rather than defend personal bias.

Much of the book points out the fallacy of oversimplification. For example, Waelder identifies explanations which are mere personifications of events. Happy events never have a shortage of claimants who willingly personify themselves as the causes of them. Hard times and disaster, however, tend to be blamed on some version of demon or devil. Waelder does not ignore the actual impact of the individual, but he attempts to view the individual in rational perspective.

In a period of history when mental health practitioners appear to be entering political activity in larger numbers than in previous times, it is fortunate that the present book is available. Waelder's volume sets a fine example of balanced, rational thinking in a most complex area of human activity. The author has remained as free from bias as any of his time. And his thought is seasoned and profound.

GERALD SABATH, Ph.D.
New York City

Books Received

THE BIRTH OF THE EGO. By *Edward Glover*. New York: International Universities Press, 1968 ($3.50) 125 pp.

OBJECT LOVE AND REALITY. By *Arnold Modell*. New York: International Universities Press, 1968 ($4.00) 181 pp.

ALCOHOLISM: THE TOTAL TREATMENT APPROACH. Edited by *Ronald J. Catanzaro*. Springfield, Ill.: Charles C Thomas, 1968 ($22.50) 508 pp.

THE USE OF SMALL GROUPS IN TRAINING. By *R. Gosling*. New York: Grune & Stratton, 1968 ($3.50) 144 pp. (paperbound)

THE PSYCHIATRIC CONSULTATION. By *Werner Mendel* and *Philip Solomon*. New York: Grune & Stratton, 1968 ($9.75) 221 pp.

THE PSYCHIATRIST. By *Walter Freeman*. New York: Grune & Stratton, 1968 ($6.75) 293 pp.

PAST EGO STATES EMERGING IN HYPNOSIS. By *Edith Klemperer*. Springfield, Ill.: Charles C Thomas, 1968 ($10.50) 270 pp.

REHABILITATION RESEARCH. By *George N. Wright* and *Ann B. Trotter*. Madison: University of Wisconsin, 1968 ($14.00) 674 pp.

WHO CAN BE EDUCATED? By *Milton Schwebel*. New York: Grove Press, 1968 ($6.50) 277 pp.

ROLES AND PARADIGMS IN PSYCHOTHERAPY. By *Marie Nelson, Benjamin Nelson, Murray Sherman* and *Herbert Strean*. New York: Grune & Stratton, 1968 ($13.75) 373 pp.

PHOBIAS, THEIR NATURE AND CONTROL. By *S. Rachman*. Springfield, Ill.: Charles C Thomas, 1968 ($5.75) 123 pp.

A TEACHING PROGRAM IN PSYCHIATRY, VOL. I, SCHIZOPHRENIA, PARANOID CONDITION, DEPRESSION. By *Peter S. Beckett* and *Thomas H. Bleakly*. Detroit: Wayne State University Press, 1968 ($3.50) 233 pp.

AN EVALUATION OF THE RESULTS OF THE PSYCHOTHERAPIES. By *Stanley Lesse*. Springfield, Ill.: Charles C Thomas, 1968 ($12.00) 351 pp.

THE SEXUAL WILDERNESS. By *Vance Packard*. New York: David McKay Co., 1968 ($6.95) 553 pp.

BASIC APPROACHES TO GROUP PSYCHOTHERAPY AND GROUP COUNSELING. Edited by *George M. Gazda.* Springfield, Ill.: Charles C Thomas, 1968 ($11.00) 323 pp.

BLACK RAGE. By *William H. Grier* and *Price M. Cobbs.* New York: Basic Books, 1968 ($5.95) 213 pp.

THE MIRAGES OF MARRIAGE. By *William J. Lederer* and *Don D. Jackson.* New York: W. W. Norton & Co., 1968 ($7.95) 473 pp.

COMBINED EFFECTS OF ALCOHOL AND OTHER DRUGS. By *Robert B. Forney* and *Francis W. Hughes.* Springfield, Ill.: Charles C Thomas, 1968 ($6.50) 124 pp.

CLINICAL HYPNOTHERAPY. By *David B. Cheek* and *Leslie M. Lecron.* New York: Grune & Stratton, 1968 ($7.50) 245 pp.

REHABILITATION COUNSELOR FUNCTIONS: ANNOTATED REFERENCES. By *George N. Wright* and *Alfred J. Butler.* Madison: University of Wisconsin Regional Rehabilitation Research Institute, 1968 (no price listed) 451 pp. (paperbound)

THE EMOTIONAL SIGNIFICANCE OF IMAGINARY BEINGS. By *Robert Plank.* Springfield, Ill.: Charles C Thomas, 1968 ($8.75) 177 pp.

TEACHING PSYCHOSOCIAL ASPECTS OF PATIENT CARE. Edited by *Bernard Schoenberg, Helen Pettit* and *Arthur Carr.* New York: Columbia University Press, 1968 ($8.50) 420 pp.

SELECTED PAPERS ON DIRECT PSYCHOANALYSIS, VOLUME II. By *John N. Rosen.* New York: Grune & Stratton, 1968 ($6.50) 172 pp.

COUNSELOR PROBLEMS ASSOCIATED WITH CLIENT CHARACTERISTICS. By *R. W. Thoreson, S. J. Smits, A. J. Butler* and *G. N. Wright.* Madison: University of Wisconsin, 1968 (no price listed) 37 pp. (paperbound)

A SURVEY OF COUNSELOR PERCEPTIONS. By *G. N. Wright, S. J. Smits, A. J. Butler* and *R. W. Thoreson.* Madison: University of Wisconsin, 1968 (no price listed) 65 pp. (paperbound)

BRAIN STORMS, A STUDY OF HUMAN SPONTANEITY. By *Wayne Barker.* New York: Grove Press, 1968 ($7.50) 277 pp.

Obituaries

NATHAN BECKENSTEIN, M.D.

Dr. Nathan Beckenstein, Director of Brooklyn State Hospital and Past President of A.G.P.A. (1958-60), died suddenly on October 17, 1968, at the age of 63.

Dr. Beckenstein devoted much of his life to serving his fellow man. As Director of Brooklyn State Hospital, he was a pioneer in improving conditions for hospital patients, bringing about many innovations such as the open door concept, unitization, and partial hospitalization. He was very active in community affairs and held many important professional positions, among which were Professor of Psychiatry at the Downstate Medical Center of the State University of New York, President of the Brooklyn Psychiatric Society, Director of the Brooklyn Psychiatric Centers, member of the Board of the Brooklyn Association for Mental Health, and President of the Grand Street Settlement. Only this year, in recognition of his humanitarianism and his many contributions in diverse areas, he was elected to the Brooklyn Hall of Fame.

In his A.G.P.A. presidential address in 1958, Dr. Beckenstein spoke of the therapeutic community and open door policy and the value and importance of group therapy in relation to them. He was among the first, in this country, to implement such programs, using his own hospital as a demonstration project. His presidency of A.G.P.A. came at a crucial time in the organization's growth, and his qualities as a diplomat, mediator, administrator, and understanding human being did much to help the Association weather this period successfully. He served on many committees and in many capacities in the organization both before and after his presidency, and he always responded, giving generously of his time, to any call for assistance or counsel.

Dr. Beckenstein translated a deep feeling and respect for people into a distinguished career of compassionate service for the mentally ill, and his passing is a great loss to his colleagues and to all who knew him.

ALBERT L. DEUTSCH, M.D.

Dr. Albert .L. Deutsch died on November 16, 1968, following a brief illness, at the age of 61.

Dr. Deutsch received his analytical training at the American Institute for Psychoanalysis and was active in the Association for the Advancement of Psychoanalysis, serving as Treasurer and as chairman of many committees. He was a Lecturer in the Association for Group Psychoanalysis and supervised group therapy at the Karen Horney Clinic. At the time of his death, he was Managing Editor of the *Journal of Psychoanalysis in Groups* and had just been elected President of the Association of Medical Group Psychoanalysts. Dr. Deutsch was Clinical Assistant Professor of Psychiatry at the Downstate Medical Center of the State University of New York.

Dr. Deutsch had been an active and enthusiastic member of A.G.P.A. for many years, serving on the Board of Directors and participating in the activities of such committees as Budget and Finance, Publications, and Membership. His many publications contributed greatly to the field of group therapy.

He had a friendly, outgoing, ebullient personality, and was enthusiastic about his work, particularly in the field of group therapy, which had been his main interest for many years.

His sudden and untimely death is mourned by the many who knew and worked with him.

LEONARD R. KANE, M.D.

Program

THIRTEENTH ANNUAL INSTITUTE

Wednesday-Thursday, February 5-6, 1969

INSTITUTE COMMITTEE

Jay W. Fidler, M.D., and Maurice E. Linden, M.D., Co-Chairmen; Helen E. Durkin, Ph.D., Chairman, Scholarship Subcommittee; Irving L. Berger, M.D., Chairman, Instructors Subcommittee; Millard Hoyt, M.D., Victor J. LoCicero, M.D., William Lordi, M.D., Max Markowitz, M.D., David Mendell, M.D., Nancy Orlinsky, Ph.D., Max Sugar, M.D., and Jeanette Targow, M.S.W.

STRUCTURE AND DYNAMICS IN GROUP PSYCHOTHERAPY

The registrants for this Institute will be assigned in groups of twelve based upon professional experience. Each group will meet four times during the two days under the leadership of one or two experienced instructors. In addition to the clinical emphasis sought by most registrants, there will be available special sections dealing with research and train-

ing for a limited number of participants who specifically request such placement.

Clinical Section: Theory and techniques of group psychotherapy will be related to the problems with which participants are grappling in their daily practice. The Institute group provides a unique opportunity for fulfilling its educational purpose by permitting its members to experience many of the same group processes being discussed. Learning is advanced when these phenomena are consciously identified, when their pertinence to therapy groups is evaluated, and their implications for therapeutic intervention considered. Both the structure and the dynamics of the group will be reflected in this experience and will enhance the cognitive and emotional aspects of learning.

Training Section A: THE DEVELOPMENT OF TRAINING PROGRAMS IN GROUP PSYCHOTHERAPY. Stanley Kanter, M.D., and Max Sugar, M.D. This section will be concerned with the issues and problems related to the establishment of training programs for group psychotherapists under a variety of auspices, as part of professional training or as a specialized service in the community.

Training Section B: PROBLEMS IN THE TRAINING OF GROUP PSYCHOTHERAPISTS. William Powles, M.D., and Beryce W. MacLennan, Ph.D. Participants will be expected to bring to this section problems which they are experiencing in the day-to-day training of group psychotherapists. Preference will be given to experienced group psychotherapists who are involved or about to be engaged in training.

Research Section: STRUCTURE AND DYNAMICS IN GROUP PSYCHOTHERAPY. In keeping with the theme of the Institute for this year, structure and dynamics will be looked at from the point of view of the researcher. What is the average or modal therapy group in terms of size and diagnostic categories of the members, in terms of its setting, and in terms of the goals of the therapist? How do these variables affect the interactions in the group? Information already available will provide counterpoint for discussions of research approaches to these issues.

TV Section: Two sections will be conducted with the use of TV monitors and videotape for immediate playback. The additional utility of self-visualization and accurate recall of moments which have been perceived in different ways will be explored and demonstrated. All tapes will be erased at the end of the Institute and will not be shown to anyone outside the group itself.

ACADEMIC STAFF

INSTRUCTORS OF THE INSTITUTE

Richard Abell, M.D., Director of Group Therapy Service, Roosevelt Hospital, New York, N.Y.

John Ainslie, M.D., Director, Research and Education, Kings View Hospital, Reedley, Calif.

Ian Alger, M.D., F.A.G.P.A., Training Psychoanalyst, New York Medical College, New York, N.Y.

Marvin L. Aronson, Ph.D., Associate Director, Group Therapy, Postgraduate Center for Mental Health, New York, N.Y.

H. Stuart Bacon, Ph.D., Private practice, Knoxville, Tenn.

Reuven Bar-Levav, M.D., Sinai Hospital of Detroit, Detroit, Mich.

Jules Barron, Ph.D., Private practice, Westwood, N.J.

Sterling Bell, M.D., Clinical Assistant Professor of Psychiatry, Southern Medical School of University of Texas, Dallas, Tex.

Milton M. Berger, M.D., F.A.G.P.A., Associate in Psychiatry, College of Physicians and Surgeons, Columbia University, New York, N.Y.

Curt Boenheim, M.D., F.A.G.P.A., Director of Group Psychotherapy, Columbus State Hospital, Columbus, Ohio.

Ina Boyd, M.D., V.A. Hospital, Houston, Tex.

Thea Bry, M.S.W., Consulting Psychologist, Newark PreSchool Council, Newark, N.J.

Leonard J. Buchner, Ph.D., Director, Psychological Services, Montclair State College, Upper Montclair, N.J.

Ruth C. Cohn, M.A., Postgraduate Center for Mental Health, New York, N.Y.

Albert L. Deutsch, M.D., F.A.G.P.A., Assistant Clinical Professor, Downstate Medical Center, State University of New York, Brooklyn, N.Y.

William Dobbs, M.D., Psychiatrist, St. Elizabeth's Hospital, Washington, D.C.

Arthur Eaton, M.S.W., F.A.G.P.A., Private practice, New York, N.Y.

Malcolm L. Gardner, Ph.D., Ohio State University, Adult Psychiatry Clinic, Columbus, Ohio.

Walter Gruen, Ph.D., Rhode Island Hospital, Providence, R. I.

Hanna Grunwald, C.S.W., Ph.D., F.A.G.P.A. Consultant, Brooklyn Bureau of Social Service and Children's Aid Society, Brooklyn, N.Y.

William Fawcett Hill, Ph.D., Youth Studies Center, University of Southern California, Los Angeles, Calif.

William H. Holloway, M.D., Clinical Assistant Professor of Psychiatry, Ohio State University, Akron, Ohio.

Walter Igershimer, M.D., Associate Clinical Professor, Department of Psychiatry, Yale University Medical School, New Haven, Conn.

Isadore Kamin, M.D., Chief Psychiatrist, San Mateo County Adult Psychiatric Clinic, San Mateo, Calif.

Stanley S. Kanter, M.D., F.A.G.P.A., Harvard University Medical School, Boston, Mass.

Lillian P. Kaplan, M.S.W., F.A.G.P.A. Coordinator and Consultant, Group Therapy, Retail Clerks Union, Mental Health Development Center, New York, N.Y.

Charles H. King, M.S., Haryou-Act, New York, N.Y.

Tom Levin, Ph.D., F.A.G.P.A., Health Careers Program, Albert Einstein College of Medicine, Lincoln Hospital, Bronx, N.Y.

Beatrice Liebenberg, A.C.S.W., Washington School of Psychiatry, Washington, D.C.

Zanvel A. Liff, Ph.D., F.A.G.P.A., Supervisor, Group Psychotherapy Department, Postgraduate Center for Mental Health, New York, N.Y.

Leon M. Lurie, M.S.W., Washington School of Psychiatry, Washington, D.C.

Beryce MacLennan, Ph.D., F.A.G.P.A., Washington School of Psychiatry, Washington, D.C.

Daniel Malamud, Ph.D., Private practice, New York, N.Y.

Irving Markowitz, M.D., Child Guidance Clinic of the Oranges, Maplewood and Millburn, East Orange, N.J.

Ida Mermelstein, M.S.W., Postgraduate Center for Mental Health, New York, N.Y.

Elizabeth Mintz, Ph.D., Private practice, New York, N.Y.

Norman A. Neiberg, Ph.D., Assistant Director, Division of Legal Medicine, Department of Mental Health, Boston, Mass.

John J. O'Hearne, M.D., F.A.G.P.A., Private practice, Kansas City, Mo.

Morris B. Parloff, Ph.D., National Institute of Mental Health, Bethesda, Md.

Alice Peters, Ph.D., Private practice, New York, N.Y.

Irving Pine, M.D., F.A.G.P.A., Department of Psychiatry, Clinical Associate Professor, Ohio State University, Akron, Ohio.

William Powles, M.D., F.A.G.P.A., Associate Professor of Psychiatry, Queens University, Kingston, Ontario, Canada.

John Reckless, M.B.C.H.B., Duke University Medical Center, Durham, N.C.

Emanuel K. Schwartz, Ph.D., F.A.G.P.A., Postgraduate Center for Mental Health, New York, N.Y.

Alberto C. Serrano, M.D., Community Guidance Center of Bexar County, San Antonio, Tex.

Ross V. Speck, M.D., Hahnemann Medical College, Philadelphia, Pa.

Edgar C. Stuntz, M.D., Private practice, West Lafayette, Indiana.

Max Sugar, M.D., F.A.G.P.A., Director of Child Adolescent Psychiatry and Group Psychotherapy, Louisiana State University Medical Center, New Orleans, La.

Bernard Tumarkin, M.D., Assistant Clinical Professor, Department of Psychiatry, University of Miami Medical School, Miami, Fla.

Joseph Weinreb, M.D., Department of Psychiatry, Vanderbilt University School of Medicine, Nashville, Tenn.

Stanley J. Woollams, M.D., Assistant Professor, Department of Psychiatry, University of Michigan, Ann Arbor, Mich.

Marian B. Yeager, Ph.D., Private practice, Houston, Tex.

Robert V. Zweber, M.S.W., Betsy Wooten Center for Psychotherapy, Reseda, Calif.

TWENTY-SIXTH ANNUAL CONFERENCE

Thursday-Friday-Saturday, February 6, 7, 8, 1969

PROGRAM COMMITTEE

Edrita Fried, Ph.D., and John J. O'Hearne, M.D., Co-Chairmen; Jacob Christ, M.D., and Henriette Glatzer, Ph.D., Co-Chairmen, Subcommittee on Workshops; Robert Goulding, M.D., and Max Sugar, M.D., Co-Chairmen, Subcommittee on Panels and Symposia; Zanvel A. Liff, Ph.D., and Rodger Moon, M.D., Co-Chairmen, Subcommittee on Workshops; Max Day, M.D., Sidney J. Fields, Ph.D., Irving A. Goldberg, Ph.D., Leonard Horwitz, Ph.D., Paul V. Ledbetter, Jr., M.S.W., Robert Mac-Gregor, Ph.D., Jean Munzer, M.D., Ph.D., William Powles, M.D., Benjamin J. Sadock, M.D., Edith Schulhofer, M.S., Elwyn M. Smolen, M.D., Robert Addison, A.C.S.W., John Gladfelter, Ph.D., Emanuel Hallowitz, M.S.W., Harris B. Peck, M.D., Clifford J. Sager, M.D., Ex-Officio.

Thursday, February 6, 3:30 P.M.

Chairman: John J. O'Hearne, M.D., F.A.G.P.A.

AS NATIONS SEE IT: PSYCHOLOGICAL IMAGES IN INTERNATIONAL RELATIONS

John Stoessinger, Ph.D.
Director, Division of Political Affairs, United Nations

ALL-DAY PANEL MEETING

Friday, February 7, 9:30 A.M. to 12:00 Noon
2:30 P.M. to 5:00 P.M.

PANEL 101. DEMONSTRATION OF DIFFERENT THERAPEUTIC APPROACHES THROUGH THE USE OF VIDEOTAPE

Chairman: John Gladfelter, Ph.D.
Participants: Albert E. Scheflen, M.D., Floyd Jack Moore, M.D., Peter Hogan, M.D., and Milton M. Berger, M.D., F.A.G.P.A.

ALL-DAY WORKSHOP MEETINGS

Friday, February 7, 9:30 A.M. to 12:00 Noon
2:30 P.M. to 5:00 P.M.

WORKSHOP 1-a. TRANSACTIONAL ANALYSIS IN GROUPS
Chairman: Robert L. Goulding, M.D.
WORKSHOP 2-a. PROBLEMS IN FAMILY THERAPY
Chairman: Norman L. Paul, M.D.
WORKSHOP 3-a. PROBLEMS IN THE FORMATION OF NEW GROUPS
Chairman: Benjamin J. Sadock, M.D.

SYMPOSIA 201 AND 202

Friday, February 7, 9:30 A.M. to 12:00 Noon

SYMPOSIUM 201. TREATMENT OF SPECIAL SYMPTOM POPULATIONS
Chairman: Sherman N. Kieffer, M.D.
Treatment of Alcoholics—Alan J. Long, Ph.D.

Treatment of Addicts—Daniel H. Casriel, M.D.

Treatment of Sex Offenders—To be announced

SYMPOSIUM 202. ACTING OUT AND ACTING IN

Chairman: Stanley Kanter, M.D., F.A.G.P.A.

Acting Out in Group Psychotherapy—Hyman Spotnitz, M.D., F.A.G.P.A.

Acting In Within Group Psychotherapy—Louis Ormont, Ph.D.

Discussant: Lawrence Edwin Abt, Ph.D.

WORKSHOP MEETINGS

Friday, 9:30 A.M. to 12:00 Noon

WORKSHOP 7. GROUP THERAPY PROGRAMS IN CHILDREN'S OUTPATIENT SERVICES

Chairman: Ernest E. Andrews, M.S.W., F.A.G.P.A.

WORKSHOP 8. TREATMENT OF RESISTANCES IN GROUPS

Chairman: Marvin L. Aronson, Ph.D.

WORKSHOP 9. TRANSFERENCE AND COUNTERTRANSFERENCE PROBLEMS IN ADOLESCENT GROUPS

Chairman: Fern J. Azima, Ph.D.

WORKSHOP 10. GROUP PSYCHOTHERAPY WITH OLDER ADULTS

Chairman: Jack D. Krasner, Ph.D., F.A.G.P.A.

WORKSHOP 11. PSYCHOANALYSIS IN GROUPS

Chairman: Maurice E. Linden, M.D., F.A.G.P.A.

WORKSHOP 12. COUNTERTRANSFERENCE IN GROUP PSYCHOTHERAPY

Chairman: Helene Papanek, M.D., F.A.G.P.A.

WORKSHOP 13. MILIEU THERAPY, OR THERAPEUTIC COMMUNITY

Chairman: William E. Powles, M.D., F.A.G.P.A.

WORKSHOP 14. EDUCATING THE PATIENT IN GROUP PSYCHOTHERAPY

Chairman: Herbert M. Rabin, Ph.D.

WORKSHOP 15. MARITAL COUPLES IN GROUP PSYCHOTHERAPY

Chairman: Jeanette Targow, M.S.W.

WORKSHOP 16. GROUP PSYCHOTHERAPY IN PRIVATE PRACTICE

Chairman: Ilona Vass, M.D.

SECTION A.
Chairman: Saul Scheidlinger, Ph.D., F.A.G.P.A.
1. Group Process and Implications for Therapy—Jacob Christ, M.D.
2. Working Through in Analytic Group Psychotherapy—Henriette T. Glatzer, Ph.D., F.A.G.P.A.

SECTION B.
Chairman: Carl A. Whitaker, M.D.
3. A Technique for the Successful Utilization of Dual Therapists in the Group Psychotherapy of Chronic Psychiatric Outpatients—Fannie B. Fried, M.S.S. and Meyer E. Golob, M.D.
4. A Comparison of Time Limited and Time Unlimited Group Psychotherapy with Schizophrenic Patients—Thomas F. McGee, Ph.D., and Meyer Williams, Ph.D.
5. Differential Uses of Multiple Family Groups—A New Approach in Aftercare of Discharged Schizophrenic Patients and Their Families—Abraham Lurie, Ph.D., and Harold Ron, Ph.D.

SECTION C.
Chairman: Jay W. Fidler, M.D., F.A.G.P.A.
6. Roles for the Group Psychotherapist in the Development of Comprehensive Community Mental Health Centers—Beryce W. MacLennan, Ph.D., F.A.G.P.A.
7. The Training of Residents in Group Psychotherapy toward Community Mental Health Responsibilities—Hugh Mullan, M.D., F.A.G.P.A.
8. A Therapeutic Community Approach to an Adolescent Inpatient Unit—Loren H. Crabtree, Jr., M.D., and James Cox, M.D.

SYMPOSIUM 203

Friday, 2:30 P.M. to 5:00 P.M.

WHITHER GROUP PSYCHOTHERAPY: WHO DOES WHAT TO WHOM AND HOW

Chairman: Saul Scheidlinger, Ph.D., F.A.G.P.A.
Participants: Jean Munzer, M.D., Ph.D., Robert MacGregor, Ph.D., and E. Mansell Pattison, M.D.
Discussant: Clifford J. Sager, M.D., F.A.G.P.A.

WORKSHOP MEETINGS

Friday, 2:30 P.M. to 5:00 P.M.

WORKSHOP 17. SUPERVISION OF GROUP PSYCHOTHERAPY
Chairman: Helen E. Durkin, Ph.D., F.A.G.P.A.

WORKSHOP 18. TRANSFERENCE IN GROUP PSYCHOTHERAPY
Chairman: Edrita Fried, Ph.D., F.A.G.P.A.

WORKSHOP 19. GROUP APPROACHES TO TREATMENT OF DISCHARGED HOSPITAL PATIENTS
Chairman: Donald Glad, Ph.D.

WORKSHOP 20. BRIEF CO-THERAPY OF A COUPLE WITH EXTENSION INTO THE FAMILY
Co-Chairmen: Asya Kadis, F.A.G.P.A., and Max Markowitz, M.D., F.A.G.P.A.

WORKSHOP 21. WORKING THROUGH IN GROUP PSYCHOTHERAPY
Chairman: Zanvel A. Liff, Ph.D., F.A.G.P.A.

WORKSHOP 22. COMBINED INDIVIDUAL AND GROUP PSYCHOTHERAPY
Chairman: Elizabeth E. Mintz, Ph.D.

WORKSHOP 23. FOSTERING INTERACTION IN GROUPS
Chairman: Norman A. Neiberg, Ph.D.

WORKSHOP 24. THE SMALL GROUP AND THE COMMUNITY MENTAL HEALTH CENTER
Chairman: Harris B. Peck, M.D., F.A.G.P.A.

WORKSHOP 25. TRANSFERENCE IN GROUP PSYCHOTHERAPY
Chairman: Emanuel K. Schwartz, Ph.D., F.A.G.P.A.

WORKSHOP 26. ANALYTIC GROUP PSYCHOTHERAPY
Chairman: Aaron Stein, M.D., F.A.G.P.A.

SECTION MEETINGS

Friday, 2:30 P.M. to 5:00 P.M.

SECTION D.
Chairman: Robert Addison

9. Group Therapy for Wives of Alcoholics—Edward M. Scott, Ph.D.
10. Group Therapy with Delinquents: Some New Goals and Techniques—Salvatore V. Didato, Ph.D.
11. Some Effects on the Group Therapist in the Group Setting: A Clinical Study—Jerry Wacks, M.D., and Stephen Bernstein, M.D.

SECTION E.

Chairman: Thomas F. McGee, Ph.D.

12. Experimental Approaches for Rapid Screening of Patients for Group Psychotherapy Treatment in a Psychiatric Outpatient Department— A. Terdiman, M.D., M. Golob, M.D., R. Baalove, M.D., and A. Stein, M.D., F.A.G.P.A.

13. A Pilot Study of Group Therapy as the Exclusive Treatment on an Inpatient Service—Edwin C. Severinghaus, M.D.

14. Group Methods—Application and Evaluation—Donald A. Shaskan, M.D., F.A.G.P.A., and William L. Moran, M.S.W.

15. Dynamics of College Students: Identity in Transition—Ernest E. Andrews, M.S.W., F.A.G.P.A.

GROUP PSYCHOTHERAPY FILMS FOR COMMUNITY EDUCATIONAL PROGRAM

Friday, 2:30 P.M. to 5:00 P.M.

Co-Chairmen: Katherine A. Wells, Ed.M., and Esther Griffin Joseph, M.S.S.

THE USE OF FILMS IN TRAINING AND COMMUNITY EDUCATIONAL PROGRAMS

Discussants: Richard G. Abell, M.D., Ph.D., Nathan Beckenstein, M.D., F.A.G.P.A., and Albert L. Deutsch, M.D., F.A.G.P.A.

Film: *Remotivation.*

Film: *The Full Circle.*

Film: *The Road to Reality.*

Film: *Working It Through—Aspects of Group Therapy.*

ALL-DAY PANELS 102 AND 103

Saturday, 9:30 A.M. to 12:00 Noon and 2:30 P.M. to 5:00 P.M.

PANEL 102. A LABORATORY EXPERIENCE: FAMILY THERAPY AND THE BLACK IMPOVERISHED FAMILY

Chairman: Clifford J. Sager, M.D., F.A.G.P.A.

Family Members: Ruth Niles, Richard Presha, Pearl Pryor, and Oscar Smith

Therapists: Nathan Ackerman, M.D., Thomas L. Brayboy, M.D., Robert MacGregor, Ph.D., and E. Mansell Pattison, M.D.

PANEL 103. TRAINING AND SUPERVISION OF THE GROUP PSYCHOTHERAPIST: A LABORATORY EXPERIENCE

Chairman: Max Day, M.D.

Participants: Henriette T. Glatzer, Ph.D., John J. O'Hearne, M.D., and Donald D. Glad, Ph.D.
Discussant: Charles S. Wilkinson, M.D.

ALL-DAY WORKSHOP MEETINGS

Saturday, 9:30 A.M. to 12:00 Noon and 2:30 P.M. to 5:00 P.M.

WORKSHOP 4-a. EARLY PHASES OF GROUP PSYCHOTHERAPY
Chairman: Jean Munzer, M.D., Ph.D., F.A.G.P.A.
WORKSHOP 5-a. TRANSFERENCE AND GROUP PSYCHOTHER-APY
Chairman: John S. Peck, M.D.
WORKSHOP 6-a. INTRODUCTION TO GROUP PSYCHOTHER-APY
Chairman: Isaiah M. Zimmerman, Ph.D., F.A.G.P.A.

SYMPOSIUM 204

Saturday, 9:30 A.M. to 12:00 Noon

SYMPOSIUM 204. EVALUATION OF THE COMPETENCE OF THE THERAPIST
Chairman: Bernard Reiss, Ph.D.
Problems in Assessing Effects of Headshrinking and Mind Expanding—Morris B. Parloff, Ph.D.
Discussant: William E. Powles, M.D., F.A.G.P.A.

WORKSHOP MEETINGS

Saturday, 9:30 A.M. to 12:00 Noon

WORKSHOP 27. MIXED ADOLESCENT GROUPS
Co-Chairmen: Victor Balaban, Ed.D., and Shirley Schechter, M.S.
WORKSHOP 28. COLLABORATION OF CO-THERAPISTS IN GROUP PSYCHOTHERAPY
Co-Chairmen: Sterling Bell, M.D., and Jaunita Kirby, M.D.
WORKSHOP 29. THE USE OF VIDEOTAPE IN WORKING THROUGH
Chairman: Milton Berger, M.D., F.A.G.P.A.
WORKSHOP 30. GROUP PSYCHOTHERAPY WITH HOMOSEXU-ALS
Chairman: Toby Bieber, Ph.D.

WORKSHOP 31. GROUP THERAPY IN THE OUTPATIENT CLINIC

Chairman: Jacob Christ, M.D.

WORKSHOP 32. DREAMS IN GROUP PSYCHOTHERAPY

Chairman: Benjamin Fielding, Ed.D.

WORKSHOP 33. GROUP PSYCHOTHERAPY WITH MOTHERS

Chairman: Mrs. Lily H. Gondor

WORKSHOP 34. GROUP COUNSELING AND GROUP GUIDANCE, INDICATIONS AND DIFFERENCES FROM GROUP PSYCHO-THERAPY

Chairman: David S. Hays, M.D., F.A.G.P.A.

WORKSHOP 35. PROBLEMS OF CONCLUDING GROUP PSYCHO-THERAPY

Co-Chairmen: Millard L. Hoyt, M.D., F.A.G.P.A., and Bernard Tumarkin, M.D.

WORKSHOP 36. HOMOGENEITY VS. HETEROGENEITY IN ANALYTIC GROUP PSYCHOTHERAPY

Chairman: Bruce L. Maliver, Ph.D.

WORKSHOP 37. GROUP APPROACHES TO THE TREATMENT OF ALCOHOLISM

Co-Chairmen: Hugh Mullan, M.D., F.A.G.P.A., and Iris Sangiuliano, Ph.D.

SECTION MEETINGS

SECTION F.

Chairman: Helen E. Durkin, Ph.D., F.A.G.P.A.

16. The Splitting of Transference: A Useful Method for Dealing with a Forbidden Oedipal Wish—Reuven Bar-Levav, M.D.
17. Sectarianism and Eclecticism in Group Psychotherapy —S. R. Slavson, F.A.G.P.A.
18. Group Psychotherapy Interminable?—Helene Papanek, M.D., F.A.G.P.A.

SECTION G.

Chairman: Tom Levin, Ph.D., F.A.G.P.A.

19. A Method of Group Psychotherapy with the Acting-Out Character Disorder—John F. Borriello, Ph.D.
20. The Role of "Fathering" in Group Psychotherapy with Adolescent Delinquent Males——Arnold W. Rachman, Ph.D.
21. Transference, Interaction, and Personality Change in Group Psychotherapy—David Freundlich, M.D.

SECTION H.

Chairman: Jeanette Targow, M.S.W.

22. Reshaping Group Treatment to Meet the Needs of a Labor Union's Comprehensive Mental Health Program—Lillian Kaplan, M.S.W., F.A.G.P.A.

23. Multiple Family Therapy: Secrets and Scapegoating in Family Crisis —Norman L. Paul, M.D., and Joseph D. Bloom, M.D.

24. The Use of the Group in Providing a Brief Therapy Service in Child Guidance Clinic—Norman Epstein, M.S.

LUNCHEON MEETING

Saturday, 12:30 to 2:15 P.M.

Chairman: Edrita Fried, Ph.D., F.A.G.P.A.

GROUP PSYCHOTHERAPY: EVOLUTION OR REVOLUTION
Luis Feder, M. Psy., D. Psy.

Member, International Psychoanalytic Assn.; Founding Member and Former President, Mexican Analytic Group Psychotherapy Assn.

SYMPOSIUM 205

SYMPOSIUM 205. A DEBATE ABOUT A NEW APPROACH TO GROUP PSYCHOTHERAPY: GESTALT THERAPY

Chairman: Robert Goulding, M.D.

An Exposition of the Gestalt Approach—Irma L. Shepherd, Ph.D.

A Challenge of the Gestalt Approach—Zanvel A. Liff, Ph.D., F.A.G.P.A.

WORKSHOP MEETINGS

Saturday, 2:30 P.M. to 5:00 P. M.

WORKSHOP 38. GROUP PSYCHOTHERAPY WITH RACIALLY AND ETHNICALLY MIXED GROUPS

Chairman: Robert Addison

WORKSHOP 39. DEVELOPMENT OF GROUP THERAPY PRO-GRAMS IN COMMUNITY MENTAL HEALTH CENTERS

Chairman: Donald T. Brown, M.D.

WORKSHOP 40. TECHNIQUES VS. GIMMICKS

Chairman: Mrs. Ruth C. Cohn

WORKSHOP 41. USE OF VIDEOTAPE IN GROUP PSYCHOTHER-APY

Co-Chairmen: Irving A. Goldberg, Ph.D., F.A.G.P.A., and Gerald J. McCarty, Ph.D., F.A.G.P.A.

WORKSHOP 42. RESEARCH PROBLEMS IN EVALUATING THE COMPETENCE OF THE GROUP THERAPIST

Co-Chairmen: Walter Gruen, Ph.D., and Leonard Horwitz, Ph.D.

WORKSHOP 43. THE USE OF GROUP PSYCHOTHERAPY FOR SOCIAL ACTION

Chairman: Tom Levin, Ph.D., F.A.G.P.A.

WORKSHOP 44. PROBLEMS IN GROUP CONSULTATION

Chairman: Beryce W. MacLennan, Ph.D., F.A.G.P.A.

WORKSHOP 45. INDICATIONS FOR GROUP AND/OR FAMILY THERAPY

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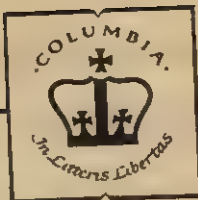
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Problems and Potential of Psychoanalytic and Group-Dynamic Theories for Group Psychotherapy

MORTON A. LIEBERMAN, Ph.D.,
MARTIN LAKIN, Ph.D., and
DOROTHY STOCK WHITAKER, Ph.D.

THE ISSUE OF THE relationship between psychoanalytic theory and the idea system we call group dynamics is not a new one.[1] A long history exists of attempts, admonitions and frank pleas for an integration of these two sets of ideas. Such an integration has been seen as a necessary step in the development of a fully articulated theory of group psychotherapy.

[1] In speaking of the psychoanalytic or the group dynamics view, we do not mean to imply that there are two strictly delimited psychological frameworks. Group dynamics as a theoretical framework does not approach the degree of unification and interrelated ness of psychoanalytic thinking. Moreover, in both psychoanalytic as well as in social systems approaches to group therapy large individual differences are to be found among theorists. In practice, it is impossible to locate a "group dynamics therapist." Nor would it be easy to find a group therapist operating strictly along the lines of classical psychoanalytic theory. Group therapy is a pragmatic affair shaped by the personal style of the therapist. But despite this diversity within each approach, it seems fair to talk of them as distinct because they are each based on distinguishable sets of assumptions about human behavior.

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Perhaps it may be instructive to review the history of these attempts at integration. The frank pragmatism of the infancy stage of group psychotherapy gave way early to a dominance of psychoanalytic thinking. For a time, this influence held sway, but efforts began to be made relatively soon to look beyond clinically based theory toward theoretical elaborations that took into account certain phenomena specific to groups. In 1942, Fritz Redl expanded upon psychoanalytic theory in his paper on group emotions and leadership (Redl, 1942). Though provocative, this attempt had no major impact on the practice of group therapy. Bion's work, which appeared in 1948, was perhaps the first integrative attempt to have an impact upon the field (Bion, 1948).

Attempts to grapple with the issue of integration increased markedly in the 1950s. Taking rather different approaches to the problem, Ezriel (1950), Scheidlinger (1952), Powdermaker and Frank (1953), Bach (1954), and Foulkes and Anthony (1957) all suggested ways of thinking about group therapy that went beyond the confines of dyadically based theory. During this same period, Berman (1950) and Ackerman (1954) pointed to the need for integration and suggested possible approaches. At the Fifteenth Annual Conference of the AGPA (1958), a major symposium was aimed at communicating across the boundaries of psychoanalytic and group dynamics thinking.

The group therapy literature of the last decade can be grouped as evidencing three strategies for resolving the integration problem. A number of schools of psychotherapy have viewed the group situation as an extension of dyadic treatment. They have based their thinking quite closely on theories which pertain to dyadic treatment, elaborating theory to accommodate certain features of the group situation. Such an approach shows awareness for new technical considerations but not for a need to reformulate concepts. Psychoanalytic theorists such as Wolf and Schwartz (1962) illustrate this approach, and in the Rogerian view of group psychotherapy, issues of trust, acceptance, and openness are treated as having the same valence as in individual therapy.

Another direction for resolving the issue of relating group dynamics and psychoanalytic thinking is seen in the approaches of Bion (1948), Ezriel (1950), Foulkes and Anthony (1957) and Whitaker and Lieberman (1964). These theories use psychoanalytic concepts of individual characteristics to describe the social system of the therapeutic group. These ap-

proaches have attempted to resolve the discrepancies in the assumptive sets of the group dynamics and psychoanalytic orientations by more or less ignoring specific group dynamics constructs such as cohesion, role differentiation, and the like. Rather, they articulate the social system of the therapy group in terms of the most basic principle of psychoanalytic thinking—symbol transformation—and they ascribe meaning to events in terms of latent forces rather than their manifest characteristics. They extend person-based concepts to the group as a whole. This is most pronounced in Bion's work which treats the group almost like a homogeneous super-person, attributing to it characteristics and properties derived from psychoanalytic thinking. Such an approach bypasses the necessity of locating an interface between psychoanalytic and group dynamics thinking; in this sense the works of Bion, Ezriel, Foulkes and Anthony, and Whitaker and Lieberman cannot be described as theories within a group dynamics framework. They are theories that have articulated social systems characteristics using a psychoanalytic framework rather than specifics of group dynamics. Thus, they have not fully exploited the conceptual potential of group dynamics theory.

Despite these meaningful attempts to develop a theory of group therapy that weds psychoanalytic and social systems concepts, we still lack a comprehensive theory of group therapy that would account for the phenomena of interest to group therapists. No theory now available takes into account all the phenomena of central importance in the literature of group dynamics—the issues of development, climate, standards, cohesion, leadership, contagion, and the like (though some theories treat one or more of these aspects of group life).

SOME CONCEPTUAL ROADBLOCKS TO INTEGRATION

The failure to develop a theory of group therapy that makes full use of psychoanalytic and social systems concepts seems to us to stem more from differences in the assumptive sets underlying the two approaches than from the simple inattention of theorists and practitioners to one or another significant dimension. Differences in the two frameworks, ranging from assumptions about the nature of man to ones about the locus of illness and the process of cure or change, have meant that certain concepts which are central to one of the two systems are more or less

irrelevant, if not logically incompatible, within the framework of the other system.

In psychoanalytic thinking, meaning exists in the inner world of the person. In a group dynamics framework there is no equivalent repository of meaning. The "self" as such is neither so developed nor articulated a concept as it is in psychoanalysis. The person gains in self-definition only in transactions with others. It is not just that these are different ways of looking at events and of organizing data. It is that each system involves a way of looking at behavior which is almost irrelevant to the systematic assumptions of the other system. From a psychoanalytic framework the interpersonal world in group therapy is described in terms of symbol transformations. The "others" in the system have their prime theoretical importance in the meaning that the individual gives to them. The characteristic and objective behaviors of the others are not as critical as what they represent symbolically. In contrast, the group dynamics point of view focuses on the interaction in the group context. The concern is with the "objective," rather than symbolic, characteristics of the "others." The influences of power, status, and role on the behavior and relationships of the interacting others are most meaningful to a group dynamicist, since he sees them as the prime determiners of individual responses. He seeks to understand these relationships because his basic assumption, not only about groups but about *man*, is that he is shaped by a process of social comparison—a process that assumes as real both the attributes of others and the structure of relationships among them.

This fundamental difference in how meaning is sought helps us understand the differing emphases the two orientations place upon exogenous versus endogenous factors. Psychoanalytic thinking emphasizes structures and processes endogenous to the individual. Group dynamics thinking emphasizes processes which involve the individual and his environment. This leads, for example, to differing views of motivation. The psychoanalytic concept of motivation as a product of interlocking systems, endogenous to the individual, has no counterpart in group dynamics. When motivation appears as a concept in group dynamics, it generally refers to a relatively simple tendency to respond to reward and punishment rather than to a highly elaborated endogenous system. Group dynamics stresses the characteristics of the total social system of which the person is a part as the motivating force, not the motivational system of

the individual. Cohesion, for example, a classical group dynamics concept, refers not only to an aspect of the social system but also to the state of the individual in that social system, i.e., it is a motivational and experiential construct which cannot be applied effectively as a conceptual tool unless its meaning relative to the individual *acting in a social situation* is considered. Thus, group therapists who employ a construct such as cohesion as well as a psychoanalytic concept of inner motivation are in reality involved in two disparate motivational concepts for explaining behavior. This incongruity highlights the need for a conceptualization.

Different conceptions of psychopathology are also implied in the two theoretical positions. Psychoanalytic theory rests on an intraphysic model of disturbance. Although group dynamics theory does not articulate a conception of pathology, it would lead to a view of disorder that emphasized the individual's relatedness to the social system. Moreover, differences can be detected in what each would consider the primary emotions. A group dynamics orientation, with its emphasis upon the integrative or the disruptive significance of social transaction, would see such states as communion, competition, and potency as irreducible or primary affects. In psychoanalytic thought these affects would be viewed as secondary elaborations of more basic emotions: aggression, dependency, and sexuality.

It is not difficult to see that the underpinnings of current group psychotherapy conceptions leave a number of important issues unresolved. It seems to us fruitless to continue in the search for a meaningful theoretical integration until we review the need for such integration. Such a review returns us to a consideration of basic questions about the purposes and practices of group therapy. Perhaps if we ask afresh what we need to know as group therapists *and* group theorists, we can respond more aptly to the purposes that integration is supposed to realize. This response may take the direction of a theory based on the specifics of therapeutic change in groups rather than integration based on an amalgam of concepts from dyadically based change and general social system characteristics.

REQUIREMENTS FOR A THEORY IN GROUP PSYCHOTHERAPY

Seven issues seem to us critical for developing an adequate theory of group treatment. Taken together, they cannot be answered by any existing theory.

1. We need to develop a theory which explicates the psychology of group membership from the perspective of the patient. What is the meaning of the group experience for the individual? We need a phenomenology of participation in a therapeutic group. Essentially, this means the articulation of categories for describing how the patient experiences the group. There may be, for example, affect states that occur *only* within a group context, fears and joys unique to becoming a member of a group. Many labels have been used to describe subjective experiences of membership—contagion, communion, interrelatedness, belongingness—emotional states derived from group relationship. A model of the phenomenology of therapy group experiences must indicate how these subjective experiences influence the therapeutic process—for example, how much belongingness is good, how much is bad, and how and when does it influence the therapeutic process? Under what conditions in group therapy does belongingness increase and decrease? Does the experience of belongingness in group therapy stem primarily from identification with the leader or from aspects of the group composition, such as, for example, similarities among the members? Such questions wait upon development of an adequate model of subjective experience in therapy groups.

2. Secondly, we must know more about the function and significance of the therapist role. How central is the leader? What degrees of leader-influence are useful or detrimental? How does the leader derive his influence? The psychoanalytic view, for example, places importance on the symbolic meaning of the therapist for the patient, an emphasis which has no counterpart in concepts of leader influence developed in group dynamics theories. Equally in need of examination are the many issues centering around therapeutic style. Therapeutic strategies range from those in which the therapist possesses a total encompassing charisma and, much like a guru, acts as the interpreter of reality and the center of emotional cathexis, to those in which the therapist acts as conductor or a social engineer. We know very little about the long-range implications, and even less about the moment-to-moment effects, of such variations in therapist style.

3. A general theory of group therapy must take into account the major regulatory forces impinging upon members, the norms or standards, the implicit and explicit values and rules which influence the

individual in a group. It must account for their establishment, development, and change and it must explain their relationship to the therapeutic process. Alcoholics Anonymous and guided group interaction, a form of group treatment for juvenile offenders, to cite but two examples, explicitly use the developing group standards and norms as sources of influence to modify therapeutically relevant behavior. The degree to which normative influences are part of all group therapeutic situations remains a major unknown.

4. Another issue is that of how a group develops into a therapeutic instead of a nontherapeutic, or even an antitherapeutic, agency? Common to all current theories of group psychotherapy is the idea that specific qualities of relationship and certain levels of communication produce positive effects. Since it is usually implied that these conditions do not exist at the start of therapy, a general theory of group therapy requires specification of how they are to be developed.

5. What changes can and do occur as a consequence of participation in a therapeutic group? The psychoanalytic position emphasizes "intrapsychic" changes—alterations in the meaning to the patient of his relationship to the environment. The changes in meaning are expressed as outcomes such as increased comfort, decreased anxiety, conflict resolution, and the like. In contrast, group dynamics conceptualizes individual change in terms of increased interpersonal competence—that is, the ability of a person to carry on effective, real interpersonal transactions. In the quest for a general theory of group therapy, what model of change is useful? How does change in groups compare to change in dyadic treatment?

6. A general theory of group therapy must include adequate concepts to account for the generalization process. How does the individual generalize the learning, growth, or development that occurs in the very special social system of the therapy group? The most widely used means of accounting for generalization has been to view therapeutic change as primarily based upon a cognitive process with a large affective component—namely, insight—a concept that has never been acknowledged as adequately accounting for change in group therapy.

7. Finally, a general theory must explicate how group therapy compares with other treatment and behavior modification methods, particularly, of course, with dyadic psychotherapy, although not exclusively.

Helping and being helped are general issues that cut across psycho-therapy, both individual and group, and a general theory requires a characterization of help-giving and help-getting. Without a help-giving model that will enable us to characterize similarities and differences among treatments, precision about the group therapeutic process will elude us.

These seven requirements for a theory of group therapy refer to issues which have been discussed repeatedly. Several theories account for one or two. Any combination of psychoanalytic and group dynamics concepts which attempted to respond to all seven, however, would be involved in some theoretical contradictions.

SOME AVENUES FOR EXPLORING THESE ISSUES

Most theories of group psychotherapy have been developed by expert practitioners on the basis of their own experience. Frequently, these theories reflect the artfulness of the theorist as therapist. They are severely limited, however, by the therapist's own experience—and in some cases by his unusual talent. They become self-fulfilling prophecies, shaping the very product the therapist is theorizing about.

Other attempts have involved intensive clinical observations of a small number of groups. Although this approach provides an important source of information for beginning the development of group-based theories in therapy, it severely restricts the variables available for study. Only a few groups are usually open to intensive study by any single investigator and, for the most part, they are confined to formal therapy groups in office or institutional settings. Such a restriction on the types studied critically increases the probability that the dimensions that may be of greatest importance will vary too little for any appreciable measure-ment. Indeed, the carefully designed process studies that have appeared in the literature in the last ten years have not been able to discover measurable variation in variables such as therapeutic style or norms and standards. While lawful discoveries may be established through such process studies, they may actually represent only a fragment of a more general relationship. We may uncover, for example, a lawful relationship between therapist interventions and outcome but never answer the more

powerful question of the amount therapists contribute to the treatment process.

The current possibilities of experimental manipulation as a research strategy also seem limited. They are limited in two ways. The conceptual precision necessary to design meaningful experimental situations does not exist. This gives rise to rather broad-gauged results in the few experimental studies that exist in the group therapy literature. For example, a recent study of the effects on patient outcome of using trained and untrained therapists (Poser, 1966), although provocative, did not tell in any specific manner what the relevant variables were. The conceptual system available to the investigator was too primitive to achieve a major breakthrough through experimental manipulation. The precision currently available in the group therapy literature can produce findings akin to the earlier studies in group dynamics, such as the classic Lewin, Lippitt, and White study of leadership styles—that is, broad generalizations that may not address the most critical issues. Moreover, experimental manipulation may not at present be the most useful strategy because of the limitations on the degree of manipulation possible in actual therapeutic situations. Although these limits are less than one would have expected fifteen or twenty years ago, they still restrict what can be discovered through experimental studies. The use of nontherapeutic experimental groups is dogged by our inability to determine their degree of continuity with therapy groups. While this problem is general to experimental social psychology, it seems particularly relevant in the area of psychotherapy. A massive assault using experimental strategies waits upon its resolution.

We believe that reliable data for theory-building must now be generated by comparative analyses of a wide variety of methods and settings in which groups are engaged in behavior modification. The contemporary scene offers many natural experiments in the use of groups for producing growth, change, personal learning, or therapy. The scope of such endeavors is broader than what most of us would call group psychotherapy. They include such recent developments as the use of Synanon games for nonaddicts and the continued expansion of T-groups and their derivative forms, such as basic encounter and personal growth groups. The variety extends far beyond these familiar examples to less well-advertised programs developed in prisons, juvenile treatment centers (guided group

interaction), and other institutions, as well as to the many more uncate-gorized or "odd-ball" programs that are proliferating throughout the country and are conducted by nonprofessionals as well as by profession-als. The heterogeneity of these endeavors in respect to their goals, popu-lations, and methods offers an unprecedented opportunity for comparative analysts. Although they are not all therapy groups in the conventional sense, their goals are overlapping. They are all interested in promoting personal growth, behavior modification, or development. We need to know how each type operates to change behavior, what kind of behavior is changed, and with what degree of success.

A strategy based on such a comparative analysis could produce the taxonomy needed for the development of a general theory of group psy-chotherapy. To illustrate, the issue of the role of group norms or stand-ards is a recurring one in group psychotherapy. The issue is not so much one of whether groups develop standards (they all do, of course), but of the *type* of norms that are developed in the specific group, their relative openness to influence, and, above all, the role they play in outcome. Some therapists utilize norms explicitly for therapeutic change. Many of the more traditional, psychoanalytically oriented group therapists, on the other hand, make no explicit use of this property of groups. Groups whose purpose is to deal with deviant behavior, such as drug addiction, homosexuality, delinquency, and alcoholism, seem to emphasize the use of normative controls for influencing therapeutic outcome in a purposive manner. Whether groups aimed at intrapsychic change have similar influ-ences is something only a comparative analysis can answer.

The difficulty of comparing data across investigators in group therapy requires a general taxonomy as the first step in enabling a constructive epistemology which can integrate the experience and knowledge of many investigators. The major barrier to this type of cumulative effort has been a limited view of the ecology of therapy groups. Without the potential for significant variation of crucial variables, our "discoveries" may be limited to secondary relationships. A broad comparative analysis, on the other hand, could result in the specification of those intrapsychic con-cepts and those social systems concepts that would be most relevant and most useful for a general theory of group therapy.

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An Analysis of Groups that Never Were

SAMUEL C. KLAGSBRUN, M.D.

THE SAME NEED THAT led to the rise of group therapy during World War II is still operative today. Many therapists work in institutional settings that cater to sick and often regressed populations, and such institutions desperately require a form of treatment that is both efficient and successful. Group therapy seems to provide a custom-made solution. Yet, many of us who have attempted to use group therapy in various institutional settings have found the going difficult. After a short time, we discover that we are directing a major part of our efforts simply to keeping the groups alive and that theoretical considerations run a poor second. In view of the need for, and the potential of, group therapy, it would seem important to isolate the factors that interfere most with the group process. This paper suggests that the culture surrounding a group is a key factor in the success or failure of group therapy.

HISTORY OF THE GROUPS

Of the four groups to be discussed, all were hindered, and sometimes paralyzed, by the surrounding culture to the extent that they never even became a group in the true sense of the word. Two of the four groups were impotent as a result of the Veterans Administration culture in which they existed. The third group was formed in an intensive, socially oriented psychiatric unit of a general hospital which admitted and discharged patients in rapid succession and in which group therapy was

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used as a tool for forced socialization rather than as a means of providing therapy on a personal and insightful level. The fourth group was formed in an outpatient clinic setting, partly as means of coping with the waiting list but mostly because of the therapist's own interest.

The patients in the two V.A. groups lived in the hospital. Most of them had been there for at least six months, and some had been there for two years or more; the record was held by one man who had been in the hospital for six years. The ward staff, made up of psychiatric residents, decided that all patients would be placed in groups; no attempt was made to select patients who would be likely candidates for group therapy since it was doubtful that any patient in the entire hospital population would fit the commonly accepted criteria. The aim of the therapists was to conduct group therapy in such a way as to benefit the patient as an individual and as a member of the ward, but it was quickly found that we had underestimated the influence of the institution and its power. The patients insisted on repeatedly telling the therapists how the V.A. worked. Despite ourselves, we soon learned the system. We became masters at knowing the benefits and the methods for gaining a foothold in the compensation status, and we became intimately acquainted with the "service-connected syndrome," a peculiar type of psychological cancer that was seemingly incurable.

Rewarding a patient by compensating him for having a symptom, although humanitarian and understandable, creates major therapeutic difficulties. But this is not the only way in which the system is overwhelming. After a number of patients had been discharged from one of the wards, word was passed around by the administration that the hospital was running a low census. This, we were told, created a delicate problem. The hospital was funded on the basis of the number of beds being occupied, and the entire system evolved from this base. We were informed that the hiring of nurses, supporting help, administrators, and even janitors depended on the number of patients in the wards. The patient who pointed an accusing finger in one session and yelled, "Doctor, we are doing you a favor. Why, this whole place is dependent on us," was expressing feelings shared explicitly by the administration. The staff knew that the budget and therefore their jobs depended on the numbers of patients in the hospital. The therapeutic goal was therefore alien to

the entire culture and was resisted consistently by both the patients and the V.A. system.

The patients knew that they would be fed, clothed, housed, and paid as long as they could demonstrate the presence of symptoms. Thus, symptoms often developed around the time when a re-evaluation of the amount of compensation from a service-connected symptom was due. Acting-out behavior necessitating the transfer of patients from open to closed wards occurred with monotonous regularity every time plans were made for a discharge.

Of all the patients seen by the author in one twelve-month period at a V.A. hospital, only two managed to leave the hospital and stay out. These two rejected the entire V.A. atmosphere, culture, and benefits from the moment they were brought into the hospital to the day they left. They had a passionate dislike for the people there; they never fit into any group activities; and they were in some ways problems in ward management. They retained their separate identities consistently, and their therapist's only contribution to their recovery was to allow them their separateness and not insist on their becoming part of the ward.

Both the open- and closed-ward groups lasted for six months. Each group met for ninety minutes twice a week. Most of the sessions consisted of group members complaining about something directly to the doctor. Very little cross talk occurred, and there was little concern shown by one member for another except at those moments when a member was perceived to be saying something threatening to the "system." This often turned out to involve a service-connected symptom or a pass.

A typical example of the type of self-defeating sabotage resorted to by the patients is presented from a session taking place during the third month of meetings of the closed-ward group. Patient T. had been hospitalized for about nine months. Patient B. had been in and out of V.A. hospitals for about five years and had never succeeded in holding down a job or staying out of the hospital for more than a few months at a time.

T. "I want a weekend pass."

B. "That's no good. Get a 10-day pass instead. What do you want a weekend pass for?"

T. "I don't know."

B. "Take a 10-day. The trouble with you is that you are afraid to cut your ties with the hospital."

T. "All you had was a weekend pass. What did you do?"

B. "I tested myself to see how strong I was. I drank."

T. "Boy, you just took care of your future passes."

The difference between the closed-ward and the open-ward group was only a matter of degree. The patients on the open ward were more subtle in their demands as well as in their attacks. They hid their lack of concern for each other under polite façades a little better than closed-ward patients did, but the culture of the open ward was, if anything, even more geared to protecting the status quo since the patients found it comfortable to live there.

Experience suggested that it would be wise to set limited goals. Thus, it was decided to attempt only to stimulate some expression of concern by one group member for another, with the hope of transforming these individuals into a rudimentary group moving toward some semblance of independence. Toward the end of the year, an episode occurred which seemed to indicate that the possibility of a group experience did exist. One group member disappeared from the ward, and the other group members volunteered to comb the countryside for him. But in discussing why he had volunteered, one patient said, "Well, Doc, we don't want to see any one of us get cut off. You know what I mean, Doc? Hell, it could happen to any of us. This ain't a great life, but when it's all you got, you want to protect it." As the discussion continued, it became clear that the missing patient did not represent another individual but was seen as an extension of each man, and he therefore had to be protected from being discharged from the hospital on disciplinary grounds. Genuine caring about another individual was viewed as a frightening thing: "It's like giving up a part of me to someone else, Doc. I can't afford to do that. Once I start doing something like that, where will it end?"

It could be argued that the dependency expressed by V.A. patients is an internal problem for each patient. It is impressive, however, to see how well this pathology flourishes and the extent to which it is nurtured by the culture of the V.A.

The third "non-group" met in the highly successful psychiatric ward of a general hospital. The goal of the ward was extremely practical. "First get better, then we'll talk" was its philosophy. Getting better meant not allowing symptoms to interfere with normal or at least acceptable functioning. The major treatment approach was based on forced socializa-

tion. Everything was handled in group meetings. Ward activities, passes, trial discharges, and even individual plans were all talked about and decided on in the context of one meeting or another. The entire system functioned on the basis of repressing anything that interfered with the practical aspects of running the ward. Psychotic symptoms were considered socially inappropriate because, for one thing, a person could not concentrate on filling out laundry slips while he was "being crazy." Discussions based on feelings and historical material were permitted to take place only after the symptom was safely put away or under control.

Group therapy was influenced to a considerable degree by this philosophy. Group discussion was mainly of a here-and-now variety. Group cohesiveness was difficult to develop since the turnover rate based on the pressure to "get well" was so high. No group existed for more than a week without a new member joining or an old member leaving it. Any expression of concern about another person was usually stated in terms of a ward problem rather than as intense feeling for a fellow patient.

The strength of the ward culture permeated everything. Patients considered themselves to be members of a ward rather than of a particular group. Frequently, patients could not remember in which room their group was meeting. The group meeting to them was only one more in a series of meetings they were expected to attend, each with a shifting population and a different limited goal. The ward culture was supreme. While eminently successful in achieving its goals, traditional group therapy could not flourish within it.

The fourth group under discussion met in an outpatient clinic in which the basic mode of treatment was individual psychotherapy. Group therapy was left to the interests of the individual therapist. Because of the nature of the outpatient population, it was very difficult to select patients who would make good group members. For example, a typical group included a high school music teacher whose sexual relationships were unsatisfactory, an exceedingly infantile housewife and mother of two, a homosexual office manager, a prostitute, a psychotic woman recently discharged from a state hospital, and three others representing other varieties of pathology and social backgrounds. Parenthetically, it is of interest that, of the two leaders of the group who emerged, one was probably the worst candidate for group therapy that could be imagined—the infantile mother. She turned out to be sensitive to the feelings of

others, able to support the psychotic woman, and though frightened of the prostitute, able to accept her to some degree. To the extent that a group feeling occasionally emerged, it was due to her efforts.

The downfall of the group did not come from internal friction but from the feeling the group members had of being short-changed. They could only rarely rise above that problem, and they could not successfully work it through. Actually, they were correct in their feelings. The entire atmosphere of the clinic was geared to individual psychotherapy. Almost all staff meetings, case conferences, and seminars focused entirely on problems related to individual therapy. Basically, many senior staff members felt that group therapy was weak therapy. They would have preferred individual psychotherapy for every patient if the clinic could have afforded it. Junior staff members interested in group therapy received little encouragement. While supervision for individual therapy was carefully worked out, experienced supervisors for group therapy sessions were few and hard to come by, and the arrangements were poorly made. The only room large enough to accommodate a group was a huge, drafty, cold, dismal hall filled with dusty chairs, an atmosphere far from conducive to promoting group feeling.

The patients reacted strongly to this environment. To begin with, they saw themselves as persons who could not afford to see a psychiatrist on a private basis and were therefore forced to come to a clinic. Once accepted for treatment and expecting to have their own doctor, they were upset to find that they had to share the doctor's time with seven competing persons. When they arrived for meetings, they found that there were never enough chairs in the waiting room, a nonverbal indication that the clinic was not set up for them. When they spoke to other patients in the waiting room, they invariably discovered that those patients were being seen by their therapists individually. And when they entered the room for their meeting, its dreary atmosphere fueled their resentment and their feeling of being cheated.

In the sessions, competition for the therapist's attention was fierce. Acting out was frequent and varied. Crises dominated many sessions, forcing the other patients into the background while the crisis patient took the floor. Preventive interpretations aimed at toning down the acting out were not very effective. Relationships between group members were shallow and existed only as a way to gain the therapist's approval.

Episodes of tragic proportions did not elicit much sympathy or support. The group "took off" only at rare intervals, and the communal insight, shared feelings, and mutual concern which are the hallmarks of a group that is functioning were almost nonexistent.

COMMENT

The patients in the four groups discussed had a number of things in common. Few of them acted as group members. Few of them wanted to be in a group. None of them had a choice since all were in settings that offered no alternatives. None of them were selected with group criteria in mind. And most of them, in spite of the fact that their backgrounds and pathologies often differed strikingly, reacted to being placed in a group in a remarkably similar way. They expressed feelings of being unwilling participants and they reacted with anger. They refused to share of themselves. They were unable to respond to and support members in need. They were very much afraid of becoming self-sufficient. It was as though all of them, the neurotic patient as well as the schizophrenic, used a final common pathway in reacting to group experience: insulation and refusal to relate to other people. The reasons for this insulation varied from group to group, but in every instance the therapist's attempt to bypass or demolish the wall that each patient had built around himself was defeated in some part by the culture surrounding the group.

In each of the groups described, the culture of the institution in which the group met fostered isolation of the patients. The V.A. did this explicitly by encouraging the dependency needs of the patients toward the institution and preventing them from forming a union toward independence. The forced socialization unit prevented traditional group therapy from taking place by discouraging intimacy and mutual interdependence. The staff feared that close relationships would create unnecessary ties between patients, making it difficult for them to leave the ward. The outpatient clinic fostered the patients' isolation by presenting a cold, indifferent face to the patients, making them feel rejected and unimportant. The patients, in turn, rejected the clinic and their "second-class" status. This attitude left them with their defenses intact and unchanged.

In contrast to these four groups, a recent group with which this therapist worked demonstrates the positive influence a carefully prepared cul-

ture can have on group therapy. About a year ago, it was decided to form an adolescent group in a child-guidance clinic. Staff conferences were held at which the plans were outlined and staff discussion and suggestions were invited. The group was formed by taking the first eight names on the waiting list because of the need to ease the waiting list situation. Thus, as in the case of the groups that failed, there was no selection of patients.

After the group began to meet, the feedback to the staff continued at regular intervals. Progress and problems were reported, and, in turn, the staff offered suggestions and useful background information available to them because of their roots in the community. Today, because of the interest and support of the staff, this group of difficult, surly adolescents—a group that might have failed in another atmosphere—is a going concern.

SUMMARY

The history of four groups is presented with emphasis placed on the culture in which these groups met. The four groups failed to become groups in the traditional group therapy sense. There was little indication of mutual support, concern, or feeling. There was little cross-discussion, and issues were handled on a superficial level. Discussions almost invariably centered on the needs of individual group members. The institutions in which these non-group groups met were either hostile or indifferent to the goals of group therapy. An example of the results of a culture favorable to group psychotherapy is presented.

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Large and Small Group Therapy in a State Mental Health Center

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THE FORT LOGAN MENTAL Health Center was opened in 1961 as Colorado's second state hospital, with the goal of serving the needs of the residents of the Denver metropolitan area. During the development stage, plans were drawn up to provide for administrative and geographic decentralization, continuity of care through the use of treatment teams having responsibility for total care, the use of transitional services, and a total hospital therapeutic community modeled on the work of Jones (1953). Wilmer (1958), Cumming and Cumming (1962), and others. In keeping with the concept of a therapeutic community, as well as for other reasons, it was proposed to minimize the use of formal individual psychotherapy for intensive care patients (24-hour and day-care) and to rely more extensively on the use of group activities and group therapy. Subsequently, various group modalities were planned, and others have evolved since the inception of the Center, including recreational, occupational, and vocational activities; conjoint and multiple family therapies; psychodrama; patient government; and pass and privilege and medication review meetings. It is with the use of small and large group therapies that this paper is concerned, with greater emphasis placed on the large group therapies both because of the particular problems involved and because most professionals are less familiar with large groups.

Almost every clinical team at the Center utilizes both small and large

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group therapies. Small groups usually consist of eight to ten patients plus co-therapists, who are often a senior and junior staff member from different disciplinary backgrounds. There is a heterogeneity of diagnoses among the patients, and the composition of the groups reflects the population characteristics of the particular team's catchment area or its special function, such as the treatment of the geriatric or alcoholic patient. These groups, as do most other intensive care activities at the Center, include 24-hour and day-care patients. Most of the continuing, or after-care, patients are seen separately. These intensive care groups meet one to three times a week and are usually open-ended. The theoretical orientation and content for these groups may range from analytically oriented psychotherapy to a group process mode such as Whitaker and Lieberman (1964) describe, with the therapists' orientation, the degree and amount of selection of the patients, and the goals for the group influencing the choice of a particular approach. The most prevalent model is that of a group process orientation, with attention to patient roles, latent and manifest group communications, group building, and identification of nuclear or group focal conflicts, as well as some scrutiny of personal and genetic material plus discussion of interpersonal relationships within the group.

Large groups consist of 20 to 30 patients plus all of the staff on duty—usually six to eight persons—with the latter acting as multiple therapists. The patients include all of those on the unit at the time of the meeting (day-care patients may not be present for every meeting). These large groups meet from two to five days a week for an hour and a half. They have been designated as large group therapy or community meetings. In certain respects these terms are synonymous because the goal, regardless of nominal designation, is to provide the patients with a therapeutic experience. More important, though, both theoretically and operationally, is the *type* of therapeutic experience provided.

ALTERNATIVE THEORETICAL APPROACHES

The Center uses the type of community meeting described by Jones (1953, 1966) as a "living-learning experience." The purpose of the meeting is for the patient to learn about himself and the effect of his behavior on others through the process of living together in the community group.

The content of group meetings is concerned with whatever is transpiring within the group or going on in regard to the group's external relationships that is of general interest. The here-and-now of the group experience receives extensive exploration so that all of the staff and patients participating may learn from their common experience together. There is no edict, however, against a patient's relating group-centered material to extragroup, anecdotal, or intrapsychic material.

More recently, we have also come to utilize some of Edelson's (1964, 1967) concepts in the large group meetings. He describes community meetings as serving a sociotherapeutic function in the therapeutic community, and he defines sociotherapy as being concerned specifically with the discovery, exploration, and resolution of intragroup and intergroup tensions. He sees psychotherapy, in contrast to this, as being concerned with intrapersonal tensions. The group tensions to which the sociotherapeutic function is addressed arise inevitably because of the values, interests, and needs associated with different administrative and professional functions. Thus, Edelson sees the community meeting not as "group therapy" but as a task-oriented group designed to examine and resolve conflicts which inhibit optimal organizational effectiveness. Discussion topics may include conflicts between the expectancies, needs, and roles of patients, therapists, and administrators of the organization or the community. Edelson's (1967) orientation might be summarized by his statement, ". . . the exercise, maintenance, and enhancement of ego functions concomitant with participation in such ego-oriented day-by-day problem-solving is a crucial characteristic of the therapeutic community in which ego-impaired patients are treated. . . ."

By way of contrast between the two models, it would seem that Jones sees large group meetings as being much more wide-ranging with regard to their being psychotherapeutic and sociotherapeutic. Edelson makes a much sharper demarcation and considers the production and examination of intrapersonal elements to be task-inhibiting. Community meetings, in his terms, deal only with the more manifest processes of intergroup and intraorganizational functions.

At this point, the Center is continuing its examination of both models, attempting to establish their appropriateness for the patient population being served, their relevance within the total context of the Center's programs, their efficacy, and their relative ease of implementa-

tion. Looking at the last question first, there are several basic considerations having to do with the development of staff expertise in working with large groups.

PROBLEMS OF IMPLEMENTATION AND TECHNIQUE

Professional staff coming from other educational or work situations have to learn how to expand their orientation to include large group work. A general tendency is to try to carry over theoretical and operational styles for small groups without sufficient regard for differences in group processes related to size. The following variables relate to increased size of the group: (1) an increased tendency to subgrouping, with more rigid hierarchies, because of the larger number of potential relationships; (2) less opportunity for members to speak, with greater potential for breakdown of intermember communication; (3) greater member and variety of resources for problem-solving, but an accompanying decrease in per member contributions, with greater difficulty in reaching consensus; (4) dilution and decreasing strength of affectational ties; (5) decreasing familiarity with others as individuals and a concomitant tendency to stereotype; (6) a trend toward skewing of participation, with those in actual or emergent leadership roles becoming more and more active and the less active members becoming more and more silent; (7) a tendency toward the phenomenon of diminishing returns in terms of the amount of new information available; (8) greater threat to the individual with regard to his participation; and (9) decrease in rates of information-seeking and exchange. Hare (1964) described these variables in work with experimental and task groups, but our observations validate their relevance for therapy groups also.

Similarly, Curry (1967) identified several of these factors in a review of the literature. He gave particular attention to the presence of multiple groupings and subsystems, observations related to those of Wilmer (1966) in the latter's discussion of clique formation. Another element is the group's potential for being overwhelmed by, and unable successfully to process, increasing amounts of information, subsequently experiencing failure and disappointment. Rice (1951) points out that, with workers, the emotional tone fluctuates from aggression to dependency and back again as the size of the group increases. Our experience with large therapy

groups is comparable; namely, there is more dependency upon the leader and more intense affective orderings.

The person undertaking large group therapy must be cognizant of these size-related processes and must modify his small group style accordingly. For many therapists this means a more directive leadership style and a higher level of activity than he may be accustomed to. His interventions must be more frequent and must include a guiding or steering function in addition to the customary functions of reflection, interpretation, and exploration. The higher level of therapist activity is oriented toward the following goals:

1. *Topic Selection*

Because of the greater potential of inputs and more diversified interests in the large group, the therapist or group leader needs to take a greater role in the selection or narrowing down of the topic for discussion. His actual selections may be determined by his theoretical orientation and by his perception of the needs or interests of the group. The selection of topics may be done by direct suggestion or indirectly. Even large groups quickly learn the therapist's preference through both his direct and covert communications. Failure on the part of the therapist to provide this kind of guidance for the group will often precipitate the dependency-aggression cycle noted by Rice (1951).

2. *Creation and Maintenance of a Safe Group Climate*

There is no question but that the large group is inherently more threatening to most group members than the small group. This can be largely overcome by the therapist's making a more assertive effort to build a safe climate in the group. This need not be done by sticking to safe topics but, rather, by instituting group norms protecting the rights and personal integrity of individuals. Examples of such norms would be, "Everyone has the right to choose not to speak or participate," "We are here to learn to understand, not to judge," "All views will be listened to with respect, and all persons will be treated with respect," "All group members have the responsibility of helping each other," etc. Whenever such norms are violated—and they will be—the therapist must move in immediately and correct the situation. Large groups, like small groups, have a tendency to try to develop cohesiveness through the use of scape-

goating and intimidation or ostracism of group deviants. The therapist, in order to maintain a safe group climate, must block these attempts and seek to build cohesion through common goals among the members.

3. *Gatekeeping*

As was pointed out in Hare's (1964) analysis, increased group size provides less opportunity for individual members to speak, a trend toward skewing of participation, increased stereotyping of members, and a tendency toward subgrouping and cliques. These effects can be partially offset by the therapist's properly influencing the flow and direction of communications. He can provide opportunities for the less verbal members to speak, limit monopolization and intimidation by more assertive members, and facilitate communication and sharing between individuals or cliques in conflict. In line with Hare's point that the larger group has a greater variety of resources among its members for problem-solving, by attending to his gatekeeping function the therapist can help the group to bring these resources into the discussion at appropriate times.

4. *Modeling*

It is not uncommon to observe therapists exhibiting behaviors which are precisely opposite to the behaviors they wish to encourage in their patients, e.g., being closed rather than open, withholding rather than giving, inhibited rather than expressive, aloof rather than involved. Because of the tendency in larger groups for there to be greater distance between members and less intense affectional ties, the large-group therapist who appears to be unexpressive or unconcerned will quickly find his group exhibiting the same traits and style of relating. The large-group therapist needs to be aware that his behavior is used as a model by the group members. By being conscious of his example, the therapist can use his behavior to help create the aforementioned "safety norms," as well as to encourage the development of interpersonal interest, concern, and affection.

The four functions described above might seem to make the therapist's role extremely controlling and dominating. While there is some degree of truth in this, the authors feel that these functions can be performed in the service of the group without the aura or spirit of domination. The large-group therapist does need to be more active and provide

more direction than does the small-group therapist. However, this is true primarily early in the life of the group. As the group matures and learns through the therapist's example, group members will begin to assume some of these functions, allowing the therapist to become less active.

The increased quantity and complexity of interactions in the larger group make it very difficult for the therapist to be aware of more than a small part of what is happening in the group. For this reason and because of the need for more active support and guidance in the large group, most large groups at Fort Logan utilize multiple therapists. There is no defined range in regard to the optimal number of multiple therapists; it is contingent upon the size of the group, the purpose of the group, the cumulative activity level of the therapists, etc.

EFFECTIVENESS OF ALTERNATIVE APPROACHES

The effectiveness of large groups is extremely difficult to assess, either as such or in their relationship to the total program. In spite of some of the difficulties attendant on their use, they do provide for a greater participation by all patients in a setting which is different from that of small groups, thus allowing another type of experiential mode. They provide an opportunity for patients to examine the interactions of the total community as it involves others and themselves. For patients incapable of extensive self-examination, this may be a vital part of treatment; i.e., the opportunity to model their behavior after that of others, though this may be more a process of socialization and conformity than the achievement of insight with internalization (Curry, 1967; von Mering and Schiff, 1968).

Which model is better—that of Jones or that of Edelson—is a moot question at this point. Jones's (1953, 1966) model is more flexible but it may provide more information than can be dealt with successfully. It is more demanding of staff because it asks that there be more exposure of self and less reliance placed on the professional's role. It allows for personal and intrapersonal problems to be examined and for the sharing of private experiences. It provides for a wider range of interventions to effect modifications of behavior.

Edelson's (1964, 1967) model restricts the potential amount of data to be processed. It is more ego and task-oriented, with the content primarily

emphasizing group task functions. It may be more difficult for some mental health professionals to adopt because of their lack of familiarity with the task group, intergroup, and intraorganizational phenomena. Another consideration is that Edelson has developed his work in settings which allow all or most patients to be in individual psychotherapy at the same time as they participate in the therapeutic community. This, of course, allows the patient a second setting in which he can explore relevant intrapsychic elements, and there is minimal pressure for him to develop these in the group setting. Where the use of individual psychotherapy is limited, small group therapies may serve this function. It may be that the two, small and large groups, can complement each other successfully and accomplish multiple objectives.

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The Impact of Videotape Recording on Insight in Group Psychotherapy

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INSIGHT, A KEY CONCEPT in many forms of therapy because it is thought to make possible more freedom of choice, can be of two basic types. The first has to do with awareness of one's own inner reactions, the second with expanded understanding of the nature of other people's behavior and of the messages they send, as well as the ability to envision one's own behavior and the impact it has on others.

In group therapy, videotape recording and playback operate to enhance the development of insight both as it relates to one's inner feelings and to one's understanding of the interactional field. The procedure used by the authors has been described elsewhere (Alger and Hogan, 1967). Briefly, a fifteen-minute segment of a group therapy session is recorded on videotape and the recording is then immediately played back over television monitors to the group. During the playback, any member of the group can stop the tape at any point in order to comment on his own reactions, on any discrepancies he sees between the way he appears and the way he felt at the time of the original recording, or on the behavior of any of the other members as he sees it. In this manner, the reactions of the group are integrated into the on-going therapy situation and further interaction among the members develops as the playback is continued.

Some clinical examples will be given to illustrate the development of various types of insight in group sessions through the use of videotape

playback. The examples will be considered under three main categories: first, examples in which different types and different levels of communication play a significant part; second, examples in which feelings and thoughts experienced in the original session can be more readily acknowledged and expressed following playback; third, examples in which aspects of the self and of others not seen during the original session are recognized during playback.

INSIGHT INTO COMMUNICATION PATTERNS

Double-Bind Pattern

When simultaneous multichanneled messages are given, along with an injunction to ignore one of the messages, several basic elements of the double-bind situation are present.

Jack made a critical remark about Jane during the course of one group. She stood up for herself and countered his remark, but her tone of voice was contemptuous. In the face of her contempt, Jack fought back and began to attack her quite vigorously. At this point, Jane said how terrible it was that she couldn't stand up for herself without being so criticized. Following this plea, Jack found it harder to continue his attack.

Although Jack was reacting to the message of contempt contained in her tone, Jane defined his attacking behavior as a response to her attempt to stand up for herself. A few moments later, when a videotape recording of this section was played back, she was startled to hear the contempt in her voice, and she recognized the double way in which she was communicating strength on one level and contempt on another. This recognition immediately broke the impasse.

Inattention to Sequential Messages

1. *Inattention to One's Own Message.* Lois and Mike had an angry exchange, and Lois defended herself quite capably despite the fact that Mike was a forceful person and could be quite intimidating. Jim, another member of the group, commented on how much he liked Lois for the way she was acting. Mike, at that point, joined in and made an affirming remark. Following this, Lois began to cry, and Mike and Jim, along with several other members of the group, responded sympathetically. Through her tears, Lois complained that she now felt very badly,

for, as was always the case, she received support only when she showed weakness and cried. Members of the group immediately challenged this idea and told her that they had responded to her strength. However, the words seemed to have no effect, and Lois continued to cry.

When this section was re-played on the videotape, she immediately saw that both Mike and Jim had indeed responded to the strength she had shown and that her tears had followed their positive reaction. She thus achieved insight into the way in which she denied the effectiveness and likability of her own strong responses in order to nourish her belief that only by acting weak could she hope to get support from other people.

2. *Inattention to Another's Message.* Ann started by recalling her competitive reactions to John during a previous group session. She said that she had been very irritated when he had been able to break through his reserve and express some of his feelings, while she has remained frozen within herself. She continued that, at the same time, she had felt a great deal of respect for him and was very pleased that he had been able to reach his feelings.

John remarked that when Ann had begun to talk about her competitiveness, he felt like having a fight, but now he felt confused and no longer belligerent. He could not understand what had happened. The therapist commented that although Ann had expressed her competitive feelings, she had gone on to say how pleased she was that John had been able to make a breakthrough. In spite of this reminder about Ann's positive comment, John was unable to remember her even saying it. When he saw the videotape playback of that sequence, the effect was quite startling. In a tone of amazement, he began to wonder how much of his life he had spent not responding to positive messages. He had an immediate association to a recent experience. While he was in a hospital, a nurse had been extremely kind and thoughtful toward him. He realized, however, that he had not made any connection with her kindness and had left the hospital without openly expressing his gratitude. At this point, he got up and crossed the room and put his arm around Ann saying that he wanted to make sure this time that someone knew how appreciative he felt.

Here John gained insight into the way in which he characteristically blocked off awareness of people's warmth. Viewing the playback stimulated an immediate association to the earlier situation with the nurse, a type of association which frequently follows the videotape experience.

INSIGHT INTO THOUGHTS AND FEELINGS

Original Unexpressed Thought

In a married couple's group, Bill expressed his desire to have an affair. While he was talking, his wife Mary made no comment but kept pursing her mouth. When this segment appeared on the playback, the therapist asked Mary what she was feeling at that time. She replied that she was thinking about having an affair herself but had stopped herself from saying this because she feared it would hurt her husband. At that point, Bill interjected that he could understand her fear of hurting him, and he could also understand how she could have been thinking of an affair herself.

From this example, Mary gained the insight that her husband was actually not as weak as she had feared, and she began to risk more open confrontation with him.

Original Unexpressed Feeling

In one group session Janet challenged Betty, who answered the challenge in a characteristically pleasant way with a smile. When this portion was played back, Betty stopped the tape and said that she was very upset to see herself smiling because, in actuality, she had been feeling very angry. From this episode, Betty began to understand how she herself contributed to her feeling of being trapped into appearing a "nice" person all the time. This incident had such impact that Betty made the decision to enter combined therapy to pursue the insight she had gained through seeing herself smile.

INSIGHT INTO ASPECTS OF SELF AND OTHERS

Unawareness of Feeling

Amy was a girl who had continually allowed her boy friend to exploit her. During one group session she began to describe a new con game that he had recently devised which took even more advantage of her than usual. As she was telling her story, the television camera caught a pained expression on the face of David, one of the group members. The anguish was so marked that on the playback David exclaimed, "Look! I'm in pain. I'm really in pain! I didn't realize it!"

David saw clearly how out-of-touch he had been with his feelings and how unable he was to make emotional connections with other people. For her part, Amy had been so involved in telling her story during the original sequence that she had not noticed the pain on David's face. It was only during the playback that both she and David became aware of the impact of her story. With this awareness, they made new contact with themselves and with each other.

Another example of unawareness of feeling occurred in Milt's group. He had watched himself on video playback during several sessions without making any particular comment. One day following a playback segment, he made a resolution to express his feelings to other people. When questioned about this, he explained that ever since he had begun to see himself on television, he had been struck by his blandness and detachment. During ensuing sessions, the change in his participation was marked, and he was experienced as being more immediately involved by the other group members.

Awareness of Others

In one session Frank was seated beside the therapist but out of his direct line of vision. On playback, the therapist noted that Frank had been quietly crying during several minutes of the recorded sequence. This demonstrates how the video allows one to review data which has been missed for purely mechanical reasons. Another example of this occurs when the zoom lens produces a close-up of a person's face, and very delicate shifts in expression are apparent which were not visible during the original episode.

Mary was quite upset about problems she was having with her son and began to feel increasingly depressed. Joan started to speak to her and expressed some sympathetic feeling. At that point in the original episode, Andy broke in and, in a most disparaging way, ridiculed Joan's sympathy as completely phony. Joan backed down and did not defend herself against the attack.

During the replay, Andy asked that the tape be stopped and quietly said that, as he was watching the recording, he saw Joan's look as she had been talking to Mary. He went on to explain that, in the original episode, Joan's face had been obscured from his view by another member

of the group and he had only reacted to the sound of her voice. Continuing, he said, "Now that I see the expression Joan had on her face, I realize that I was wrong and that she really *was* feeling sympathetically toward Mary. I'm very sorry for what I said."

This demonstrates the usefulness of the videotape in allowing a review of an episode as many times as necessary so that aspects which have been lost during the original experience can be lived again and reacted to again.

DISCUSSION

The use of videotape recordings in psychotherapy seems to hold much promise. For the first time, objective visual data is available for immediate review; and since the patients are included in this reviewing process, a more democratically oriented therapeutic relationship is encouraged.

After one experience of videotape playback, patients often gain an awareness of their behavior that has eluded them during months and years of verbal interpretation. Another important factor is a general lack of defensiveness on the part of patients. Contrary to what might be thought, people seem generally pleased to learn how they appear to others. This supports the finding that motivation to change is frequently increased when videotape playback is used. The desire to change is experienced by the person as coming from himself as a result of his own observations and conclusions rather than being imposed upon him by some outside authority.

Insight has always been a central issue in psychotherapy. The work of Bernard S. Robbins (1956) linked insight with activity and change. Robbins made the differentiation between "intellectual insight" and "emotional insight" by noting that it is said that a patient has achieved "emotional insight" when his behavior changes. It would seem that when insight is concretely connected to actual events, it has more impact and is more readily acted upon. To read something may bring intellectual insight. To be told something may produce a similar and possibly a more effective consequence. To be shown something has even more impact. But actually to do something oneself makes it possible to experience it more fully, and hence makes it possible to integrate it more completely into

one's behavior. The use of videotape in group psychotherapy gives promise of enhancing the development of this kind of insight.

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Psychoanalytic Treatment of Severely Disturbed Juvenile Delinquents in a Therapy Group

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It has generally been assumed that inveterate juvenile delinquents with severe character disorders are not amenable to intensive treatment aimed at accomplishing major personality changes. Previous work by Redl (1945), Slavson (1947), McCorkle et al. (1958), Eissler (1950), Schulman (1956) and others has suggested that this type of juvenile delinquent is only likely to respond favorably to supportive therapy that does not attempt to focus in depth on self-awareness.

We have found, however, by treating such seriously disturbed delinquents in psychoanalytic group therapy five times a week, where direct focus on personality exploration is explicit and consistently maintained from the outset, that it is possible to involve them successfully in deeply meaningful and highly productive understanding of themselves. The approach described here has been developed and implemented in a number of treatment centers operated by the New York State Division for Youth (Luger, 1964).

In our use of psychoanalytic group therapy the objective is to work

toward the maximum psychoanalytic goal of reconstruction of character structure in view of the severely disturbed life functioning of the youngsters treated. The specific population for which treatment is provided consists of adjudicated mid-adolescent delinquents whose extremely poor response to probation indicates that commitment to a state reformatory is inevitable. In their contacts with the probation officers, as in their contacts with all authority figures, various forms of apparently impenetrable resistances are manifested. Typical is the garrulous, quick-witted, seemingly friendly youth who deftly turns aside any focus on himself, bespeaking the shrewd, skilled "sharpie" who is easily able to talk himself out of any troublesome situation, as well as the openly defiant youth who readily admits to his delinquent behavior with no apparent remorse whatsoever, and who very aggressively proclaims, "Send me away. Do what you want, I don't give a shit. I do what I want and no one's gonna make me do anything I don't wanna do. I didn't ask to be on probation in the first place."

The extreme recalcitrance of these youths is equally reflected in their responses to a wide variety of community resources from which they have been unable to benefit. They seem to be completely unreachable and hopelessly incorrigible. In short, as one boy's probation officer put it, "This kid is destined to be shot down by the police or be behind bars for life." The severity of the boys' characterological difficulties is such that it appeared to us they could only be helped if they could be reached through a very direct, highly intensive treatment approach aimed at effecting very substantial changes in their personalities.

For the most part those boys who come into treatment are motivated entirely by the realization that otherwise they are destined for commitment to a penal institution, although occasionally there is also a momentary hopefulness for themselves generated by the enthusiasm of their probation officers. It is usual for a boy to choose treatment as the lesser of two evils rather than because of a motivation to change. Entering treatment is established as a condition of their probation, and they are made aware that refusal to do so will place them in serious jeopardy with the court. In some instances boys who drop out of treatment are immediately committed.

Although most of the youngsters often seriously contemplate breaking off treatment, especially during the early phase of analysis of their resistance to self-awareness, termination rarely occurs without the agreement

of their therapist. Seldom do youngsters who have terminated treatment have to return to court because of further difficulty. In many instances youngsters have voluntarily sought and successfully utilized further help in the community after experiencing difficulties in carrying out their objectives. And occasionally it has been necessary for some to return for further intensive treatment. All of the youngsters have maintained contact with the therapist by letter or telephone, and many have made personal visits.

Special considerations in our decision to attempt psychoanalytic treatment of these youngsters in a group were dilution of intense hostility toward the therapist as an authority figure (Peck and Bellsmith, 1954), exposure of their characteristic difficulties of deep-seated distrust and fearfulness as manifested in transference responses to each other (Franklin, 1959), and vitally needed peer support of growth strivings at a time when intense, underlying passive-dependent longings threaten to overwhelm them (Fried, 1956).

In deciding on the frequency of the sessions, several considerations guided our thinking. The very low tolerance of delinquents for frustration and anxiety, coupled with their predilection for discharging tension through impulse behavior, suggested the desirability of intensive treatment on a daily basis. Especially in the early stages of treatment they need almost constant support and encouragement to be able to come to grips with the deeply rooted, intense feelings of worthlessness that generally lurk behind their persistent efforts to block off self-awareness. As expressed by one youngster, "I been coming in here night after night and arguing with you guys, but it's no use. All my big talk is bullshit. The truth is there's hardly a guy in here I'm not afraid of. It's so hard to admit what I really feel about myself. I been playing a game all these years of acting tough and smart when I really feel like shit. I'm scared when I fight and in spite of all my big talk I really feel stupid. I feel like I'm nothing inside."

At such times the respectful silence of his peers, if not their outright sharing of such feelings or expression of admiration for the courage of such honesty, greatly helps a youngster to hang on to an image of himself that is not devastating and alleviates his strong impulse to quit treatment.

The freedom to express feelings on a daily basis also greatly contributes to keeping tension down to therapeutically desirable propor-

tions. The acceptance in the group of spontaneous outbursts makes it possible for feelings to be released without the consequences of retaliation or ridicule they deeply fear. "Blowing one's cool" is initially a source of great shame to them, primarily, we believe, because in fact they have such very poor control over their emotions and impulses when these are strongly aroused. The feeling of helplessness experienced at such times, and the ever-present possibility of being overwhelmed, is a major cause for the intense feelings of inadequacy present in these youngsters.

The release of feelings that gradually occurs has the dual value of helping them to know what their feelings are and to recognize their difficulties in coping with them. Cliff, a deeply sullen, uncommunicative youngster of formidable physical strength, had an easily aroused, uncontrollable temper that led to innumerable instances of his beating up almost anyone he became involved with, including teachers, parents, siblings, and peers. He was totally unaware of the intense anger in himself that was so obvious to the rest of the group. Even when it erupted in explosions of obscenities, threats of violence, and physical attacks, he insisted that he was not angry, until he finally realized that no one would take advantage of him during such episodes of loss of self-control. The weakness he experienced at such times made him feel very vulnerable to attacks from others, as well as deeply ashamed of his extreme crudity, which at this point was still the only way he was able to express what he was feeling.

The frequency of the sessions also has the great advantage of helping the group members to detect resistances in each other that often are employed with considerable skillfulness. For example, one boy, Eddie, appeared to be sincerely and earnestly trying to talk about himself. "I want to very much," he said, "but I just don't know how to begin." When pressured, his tears and look of pain aroused considerable sympathy from his peers: "Don't you see he's all upset? Let him take his time. He'll come around." When eventually it became clear to them that he was not going to come around and his behavior was perceived as resistance by the group, Eddie admitted he had enjoyed the game he'd been playing and had laughed to himself about how once again, as on many other occasions, he had been able to manipulate others successfully.

Daily sessions also have the value of being a strong, concrete indication to the boys that they are regarded as people worth spending that

much time with. The frequency with which the therapist is willing to work with them is an important contribution to their involvement in therapy because it signifies to them his interest in them as well as his belief in their potential. It also reinforces their growing realization that their situation is a gravely serious matter and that they have come to a crucial point in their lives. The therapist tells them at the outset of treatment, "You are here on the recommendation of the court because of the problems you have had in the community. We are going to give you what may very well be your last chance to better understand yourself and your problems so that you can live in the community as a more mature person capable of making a worthwhile life for yourself." In this and many other ways during the course of treatment, the therapist stresses that he regards therapy as an opportunity they are very fortunate to have available to them.

We found that one of the most significant advantages of group therapy is the influence which these youngsters have on each other in stimulating their interest in observing and understanding themselves. Usually, when a boy enters treatment, he is disturbed by, but also intrigued with, the extremely frank expression of thoughts and feelings by his peers about themselves and each other. As one youngster in his third session put it, "I never heard guys talk like this before. At first I thought they were just ratting, but now I can understand that they're being honest about themselves and each other."

However, in spite of any initial positive reaction to the therapy group, these youngsters do not readily engage themselves personally in treatment, and, in fact, cannot because of the depth of their resistances. Here, again, group therapy proves to be of great value because the responsibility for participation can be shared with peers. This enables each youth to become involved in the therapeutic process at whatever pace is possible for him.

During this phase of treatment there are two particular advantages of the group. The satisfactions gained from the friendships the boys begin to develop help to sustain them in treatment while they are fighting as actively as they need to against self-awareness. These relationships also contribute greatly to a gradual development of accurate knowledge about themselves because of the importance each youngster attaches to the reaction of his peers.

When these youths become deeply involved in therapy, they are keenly perceptive about each other and highly adept in a vernacular rendering of their observations. At times, their alertness to the subtlest of defenses is remarkable and has great impact on even the most resistive youngster. Though often their initial reactions to comments about themselves from peers are characterized by fear and hurt, which they conceal behind hostile attacks, it becomes increasingly difficult for them to reject observations of people they know to be their friends. As they work through together their various fears of each other's reactions, there is nothing about themselves that they cannot bring out freely and constructively in the group.

Tony, a very muscular youth with a reputation for being a good fighter, had so badly beaten up a teacher and a policeman that they required hospitalization. He came from a family in which an older brother he greatly admired for his toughness and popularity with girls sharply contrasted with their passive ineffectual father who depended heavily on their aggressive, domineering mother. Tony finally revealed in the group, with much anxiety, "Before I came here I was giving blow jobs to my brother, and I would lock myself in the bathroom and jack off with my mother's bra and panties on." He spoke of this not simply for the sense of relief of getting it "off his chest" but also because of the feeling that at last here was a chance to understand what made him want to do these things.

The openness which makes sharing possible grows out of the trust they come to have that their peers will try to understand and help while continuing to respect each other. That they respond to each other in such positive ways instead of with their previously characteristic contempt or disgust can be mainly attributed to the youngsters talking about such experiences with their feelings of inner torment and suffering revealed, rather than masked, as before, behind a facade of toughness and cold indifference. Ray, who at first sat in complete silence following Tony's revelations, said, "Man, when I first heard Tony talking about these things, I thought, 'How could a guy do such things.' I felt like telling him he was disgusting. I didn't want to have anything to do with that nasty mother-fucker. But when I sat there watching Tony talking and crying, I couldn't help feeling sorry for him and feeling this guy's got a deep

problem and needs help. He's in trouble and he's gotta bring that shit up in the group."

Their positive responses are strongly fostered by their awareness of the courage it takes for a boy to bring out problems which are extremely embarrassing to him. Roger, a "nervy guy" who would do anything on a dare, usually took the lead among his peers in delinquent acts which seemingly showed a great deal of courage. For some time he had been primarily concerned like the rest of his peers with making a good impression on the group. Finally, he broke through this defense. "Some of you guys may not want to have anything to do with me after this meeting. I care about what people think of me, but I can't let it stop me any more from talking about the things I feel inside of me. I know it's for my own good and it's gonna help me." He went on to talk about his desire for passive homosexual relationships, which up to that point had been concealed behind a tough exterior. "I keep saying how I'd like to screw that cat, but I've been lying. All I can think of is how I'd like him to do it to me. I want him to just hold me like a baby and make love to me."

In time it becomes easier for them to bring out their shame-laden impulses and actions because they come to see these in perspective as only a part of themselves or each other: "This doesn't mean I'm all bad, that I'm no fuckin' good." And, also, they gradually understand that what superficially appears to be crazy or disgusting stems from basic human feelings and desires which are present in everyone.

Those boys who can openly admit to their doubts and fears about themselves greatly encourage other youngsters to do the same. In fact, to be able to do so gradually comes to be a measure of strength among them. This represents a major turning point in treatment. As expressed by Ralph in talking about whether commitment to a penal institution was a less painful prospect than the anxiety aroused by facing oneself: "Sure, so I'm a little guy and don't fight so good, and those hard rocks up there can probably get to my ass, but that's just ass. You guys are getting into my head and fuckin' up my mind. Up there I know it's hard and you're locked up. But you mind your business and do what you're told, you finish your time, and you're home free. You don't have to think and talk about things you don't want to talk about that bother you." Thus, therapy comes to be seen as a very difficult challenge and is

respected by them as a true test of their manliness rather than "an easy out."

Further incentive comes from their being deeply impressed by those youngsters who, having faced and worked on problems within themselves, have begun to show a calm and manly dignity based on a growing feeling of genuine self-confidence that is dramatically in contrast to the brash and patently superficial bravado prominent among newer members of the group. That those with whom they are so closely identified can achieve such a constructive outcome from their efforts to know themselves provides them with a concrete stimulus that greatly strengthens their determination to involve themselves more purposefully in treatment.

The many ways in which group therapy proves useful in helping to overcome resistances parallels the group's value in resolving distorted perceptions of others and consequent inappropriate behavior toward them. Through a constant process of comparing and evaluating their various perceptions of each other, they are able, in time, to attain a high degree of objectivity about the accuracy of their impressions and the appropriateness of their reactions to each other. Most of the youngsters rarely remain unaware for very long of distortions which occur among them. Not surprisingly, their perceptiveness is more true at first with regard to their distortions of each other than of the therapist. Their transferences to the therapist are more deeply entrenched and for a longer period of time appear more valid to them. But as a result of the insights and strengths they gain from working through their various distortions of each other, they eventually become better prepared to question the accuracy of their impressions of the therapist.

As their capacity to cope with interpersonal difficulties increases, they are able to experience affection, friendship, and even love toward each other and the therapist of an intensity which they have rarely, if ever, experienced before in past associations with others. Their previously intense underlying feelings of depression and despair are based to a considerable extent on the isolation and loneliness that come from an extreme lack of emotionally gratifying attachments to others.

Nat, who had a long history of extremely sadistic behavior, including vicious assults and destruction of property for the pleasure it gave him to watch others suffer, only permitted himself to be close to the animals

he kept as pets. For many months he remained completely detached emotionally in the group, until very gradually he began to develop a friendship with another boy. In the session following a fight which had occurred between them (Nat had hit the other boy so hard that he fell and sustained a concussion for which he had to be hospitalized), Nat was asked how he felt about what had happened. He expressed some regret, but the others did not believe him because they had never known him to have concern for anybody. When they pressed him to admit that he was not really sorry, Nat broke into tears and revealed with intense anguish how badly he felt and that this was the first time he had really cared about anyone.

Bob, a tall, husky, 18-year-old, who, in addition to numerous burglaries, had stolen 43 cars during his long history of delinquency, initially called the therapist "the warden." His attitude toward the therapist was a sullen detachment covering thinly veiled feelings of hatred. Later, after Bob had permitted himself to become more closely involved with the therapist, he was much like a love-starved little boy who had found his long-lost daddy. He constantly wanted to engage in physical play with the therapist on a rough-housing level that would have been appropriate to a four-year-old boy, and he expressed an intense desire to be adopted by him.

Gradually, the nature of his relationship to the therapist changed until it ultimately developed into an abiding and profound love for him as a man he deeply cherished and respected but a person quite separate and different from himself. He openly and easily expressed his feelings and thoughts to the therapist and was genuinely open to and interested in the therapist's responses to what he had to say, without, however, looking to him to plan his life or solve his problems for him. Also, he was often able to be sensitive to, and considerate of, the therapist's feelings and needs, and at times he was quite helpful to him without sacrificing a due concern for his own needs and interests.

The evolvement of strong, close relationships with other group members and the therapist are deeply gratifying to these youngsters and undoubtedly are the most vital part of the therapeutic process. The experience of these relationships does much to bring the boys into conflict with their own antisocial attitudes and behavior and are in great measure responsible for the depth of their involvement in working

toward personality changes. They become keenly aware of their own serious difficulties in being able to develop and maintain such relationships. Overcoming these obstacles within themselves comes to matter a great deal to them because they so strongly want to build lives for themselves in which deeply meaningful friendships are of central importance.

One further aspect of the value of group therapy for these youngsters is that the challenge posed by new group members closely resembles the problems which they face in their daily living situations. Their newly acquired positive strivings arouse intense antagonism both in new boys in the group and in former neighborhood companions. Ultimately, they are able to cope with these assaults constructively through achieving a realistic sense of self-worth and a greater awareness and understanding of the problems of others. Their increased capacity for positive reactions to conflicts with others is particularly apparent at first, of course, with group members, but gradually increases with peers and adults in their daily lives.

When they reach the point at which their ability to work out problems within themselves and to develop satisfying relationships with others are fairly well consolidated, they then feel sufficient self-assurance to attempt an adjustment in the community independent of the therapy group.

SUMMARY

We have attempted to describe various significant aspects of the therapy group which make it possible to utilize psychoanalytic treatment successfully with juvenile delinquents with severe character disorders. Of crucial importance is that treatment be on a five-times-a-week basis and that emphasis on self-understanding be consistently maintained from the outset. In particular, we have observed that the members of the group are of invaluable help to each other through their very presence, by their influence on each other in stimulating interest in self-understanding, by the similarity of their problems and their insights into them, by the support and encouragement they give to each other during times of great stress, by their skillful confrontation of resistances and their awareness of transferences, and through the salutary effects of the relationships which they develop with each other. We have concluded that seriously disturbed

juvenile delinquents, who are so often regarded as untreatable, can accomplish major personality changes leading to successful adjustments as a result of intensive psychoanalytic group therapy.

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The Similarity of Therapy and Supervisory Themes

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Searles (1955) observed that "the processes at work currently in the relationship between patient and therapist are often reflected in the relationship between therapist and supervisor." He distinguished between countertransference and a "reflection process," the latter referring to the possibility that problems in the supervisor-supervisee relationship may be a reflection of problems in the therapist-patient relationship.

Ekstein and Wallerstein (1958) found that understanding interactions between the supervisor and the resident can illuminate problems between therapist and patient because the resident-therapist "remains the same in both situations and brings his specific abilities and attitudes and his problems in learning to each." Earlier, Stanton and Schwartz (1954) documented how hospital staff conflict may precipitate and foster patient conflict and crisis.

The author has observed similar phenomena in such different group settings as continuous case seminars, supervision of co-therapists, group supervision of group counseling or group therapy, and "post-mortem" staff meetings following patient-staff ward meetings. That the themes of formal therapeutic sessions with patients are often similar to themes of subsequent supervisory or administrative meetings is illustrated in the following examples.

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CLINICAL MATERIAL

Continuous Case Seminars

The first set of examples is taken from a continuous case seminar conducted by a psychoanalytically oriented supervisor for a group of third-year psychiatric residents. One of the residents had a patient in therapy, and he brought to the seminar process notes drawn up after each session with the patient. This same resident-therapist also made notes of the discussions of the seminar, and as both the supervisory seminars and the course of psychotherapy drew to a close, similarities between the themes of the psychotherapy hours and the interactions of the members of the seminar were noted. In the twenty-eighth meeting of the seminar, material was discussed from therapy session number 65 which showed that the patient was dealing with the growth dilemma and his fear that if he grew up, he might cut himself off from all dependency gratification. Simultaneously, the residents talked about their future plans after the completion of their residency—where they might locate, what their earning power might be, etc. One resident commented, "We're growing up, too." Two weeks later the supervisor warned the resident-therapist that he was forcing his defenses onto the patient because of his own ambivalence about termination, and he was encouraged to let the patient terminate in his own style. The other residents supported the resident-therapist and expressed confidence in his ability to handle termination adequately. In the last supervisory session, the material presented showed that the therapist was communicating to the patient that he would miss being indispensable to the patient. A similar theme occurred in the seminar, with the supervisor conveying his own indispensability to the residents.

The second set of examples is taken from a continuous case seminar conducted by a psychoanalyst with a group of first-year residents working with inpatients. In the first supervisory session the resident-therapist reported material which indicated a competition for control between the patient and the therapist. Similarly, some of the other residents competed with the psychoanalyst for intellectual dominance and pre-eminence within the seminar. A week later, the resident demonstrated his anxiety over interpreting the patient's resistance. Likewise, the therapist himself resisted some of the comments made in the seminar. Several resi-

dents confronted him, but he defended himself successfully. In the third conference, it was evident that the patient was continuing to resist by manipulating and controlling the therapist and by attempting to provoke him, while the therapist, for his part, still seemed to fear a confrontation with the patient. In the seminar, one of the coresidents became much more directive in discussing the therapist's resistance, but the others held back. This time, a group discussion resolved the issues. In the next seminar, the resident presented material which indicated that he was more in charge of therapy and less fearful of the patient's anger, and the patient gave evidence of the beginning signs of a therapeutic alliance. In the seminar the resident who had been direct the previous week was fearful of hurting the therapist and set limits on the responses of another member of the seminar. This conflict was discussed, and there evolved also a more cooperative working alliance among members of the seminar.

We jump now to later meetings of the seminar. In the thirtieth meeting, material from the previous week's therapy sessions indicated that the patient was anxious about getting a job and was turning elsewhere to obtain the support he felt he was not getting in therapy. In the seminar the therapist described himself as being helpless to interpret the patient's acting out of his current conflicts, and he indicated that he felt quite depressed over his own progress in the residency. The seminar leader and members empathized with him and his difficult position with the patient. Three seminars later the therapist described how he was involved in a battle with the patient over passes. When his colleagues pointed out that he seemed to be angry at the patient for having missed an appointment, he denied this and a battle developed in the seminar itself. In the next meeting of the seminar, the patient seemed to be denying any problems he might be experiencing in separating from the hospital. The therapist stated that he "tries" to confront the patient but "cannot." The members of the seminar group, themselves beset by the impending loss of the seminar leader, attempted to get the therapist to see what he was not doing: "You've been with us for eight months; haven't you learned anything?" The resident-therapist resisted and pleaded helplessness. One of the coresidents mentioned the termination of the seminar, another resident seemed upset about this, and the seminar leader treated it matter-of-factly, not exploring any affect the residents might be experiencing.

Supervision of Group Therapy Cotherapists

In a group of five inpatients meeting weekly with their respective, nonhospitalized spouses, therapy was conducted by a social worker and a nurse acting as cotherapists; a second nurse attended the meetings as a recorder, and a psychiatrist supervised. Parallel themes developing in the therapy and supervisory sessions were often pointed up in an attempt to facilitate the supervisory process. At one supervisory meeting, material presented described a therapy session during which the members of the group had experienced initial anxieties about opening up to each other, particularly in front of the spouses. Likewise, in supervision, the cotherapists found themselves unable to open up and complained of the fact that they "didn't know" the supervisor. In another supervisory session, it was noted that the recorder had been communicating nonverbally with a particular patient, and as a result he was using this special relationship to avoid involvement with other members of the group. In the supervisory session the recorder accused one of the cotherapists of being prejudiced because he had kept a white couple out of an all-Negro group. It was pointed out that, in both therapy and supervisory sessions, the recorder felt isolated, but focusing on this accomplished little and the recorder missed the next supervisory session.

In a later supervisory session, the group appeared to be struggling with getting closer to each other, and one cotherapist proposed that they meet outside the session to discuss group process theory. The other cotherapist pointed out that under the guise of "getting closer," the cotherapist continued to be very intellectual and maintained a good deal of distance. This was discussed and the therapists progressed in getting to know each other better. Another supervisory session looked at the patients' discussion of heterosexual issues in the group, and the recorder, by forgetting her notes and becoming provocative with the supervisor, seemed to be attempting to pair off with him.

Group Supervision of Group Counseling and Group Therapy

A group counseling program for incarcerated delinquent and youthful offenders involved nine counseling groups led by a chaplain, dentist, general physician, teacher, vocational instructor, correctional officer, cook, medical technician, and caseworker. The program was supervised by the

institution psychiatrist and psychologist in a weekly one-hour seminar, at which time the group leaders presented and discussed material from the counseling sessions. Early in the life of the seminar, one of the group leaders presented material which indicated that his group was in conflict over trusting the staff and being accepted by the staff. In the supervisory session, this material provoked discussion about how in the process of working with the boys, the leaders might get attached to them but that getting "attached to people is okay." The group leaders seemed to feel that they had had considerable experience in working with delinquents, "knew something" about it, and could trust each other for mutual assistance. Several weeks later, in one group it appeared that the boys were testing out whether the group leader was trustworthy. Within the seminar itself, the members were asking the psychiatrist whether or not he was participating in the session simply to get a "name" for himself or whether he liked the leaders and was interested in their work. Several months later, a counseling session was discussed in which the focal conflict was the wish by the boys to do well versus their fear of failure; this was expressed by initially expressing anger at failure but finally admitting that anyone could fail. At the same time, a number of the group leaders were themselves experiencing a sense of failure in working with their groups, and as a result the cosupervisors became more active in the seminar. One of the members said as he left the session, "We got something out of it today." About a month later, the leaders reported that attendance at the group meetings was beginning to drop off. Attendance at the seminar was likewise dropping off, and one of the questions that was raised was whether or not the institutional administration really supported the counseling program or whether a number of competing priorities were not being communicated to both inmates and staff.

About three months later, the boys in one of the groups were competing with the leader, but, at the same time, fearful of being killed or injured in retaliation, they decided to be like the leader and submit to him. During the seminar the psychiatrist complimented the leader on his presentation and asked him to present again the following week. Other members of the seminar admired this particular leader and began asking him about some of his previous experiences, particularly his war experiences. One member turned to the psychiatrist, however, and warned, "Don't let him take over."

The next examples are drawn from group supervision of three inpatient groups operating on a general psychiatric ward. Staff personnel for the groups consisted of nurses, social workers, psychology interns, psychiatric residents, and activity personnel; they were supervised by weekly one-hour seminars conducted by the administrative psychiatrist and the nursing educator. At one supervisory session, the theme of the group meeting under discussion centered around the therapists' attempts to get their groups to deal with intragroup rather than tangential issues. In the supervisory seminar, the members offered further information about patients in the group in an attempt to avoid the questions the leaders were asking about the focal conflict and themes of the session. Later, material from a group was presented concerning how the group was going to deal with the loss of a cotherapist; after some initial denial, the patients had focused on their feelings about separation, though they closed with an intellectualized discussion. At the same time, in the supervisory session the leaders announced a reshuffling of the cotherapy assignments. One cotherapist and recorder tried to cling to each other to compensate for the loss of the other cotherapist. One departing cotherapist came late and was silent during the seminar. Another cotherapist initially denied any impact of his leaving on his group, but eventually admitted some recognition of his importance. Initially the staff members seemed depressed but closed the meeting by discussing how the therapy groups were handling separation and uniting around a solution of: "Let's examine this together." The following week the patient groups focused on their anger at the departure of several cotherapists and dealt with feelings of separation. The group leaders spent the supervisory session expressing their own feelings about leaving and separating from each other.

"Post-Mortem" Staff Meetings Following Patient-Staff Ward Meetings

On this same general psychiatric ward, an integral part of the treatment program is a daily ward meeting which all patients and staff are expected to attend. A subsequent team meeting then focuses on the dynamics and interactions of the ward meeting. At a Friday morning ward meeting, the group discussed a fight which had taken place the previous evening between two male patients. Someone suggested that two female patients had been influential in provoking the fight, one by stimulating jealousy among the males and the other by setting up one of the males as

the unit protector. The conflict in the ward meeting seemed to center around questions of masculine adequacy and female provocation and the anger and guilt people felt about such issues. The solution was to scapegoat one of the patients. In the team meeting afterwards, the staff struggled with similar issues of masculine adequacy and female provocativeness, particularly between a male resident and a female social worker. The Monday ward meeting focused on the male patients, with the general tenor being that to open up and talk about problems was too painful for many of the male patients and that, therefore, they tended to discharge tension by eloping, taking unauthorized medication, self-mutilation, misusing privileges, faking a seizure, etc. In the team meeting that followed, male staff members were extremely active in the discussion, while female staff members were quiet and passive. In the Tuesday ward meeting, two cliques of female patients were apparent: the two females who the previous week had been accused of provoking the fight and a group of females who resented their dominance. This second group attacked a male aid and the chief psychiatrist. The male patients supported the first group, and the male patient-chairman of the meeting became more and more active and more and more angry. During the course of the ward meeting a male staff member openly disagreed with his female cotherapist about their small group having special meetings on its own. She opposed the idea but he announced at the close of the ward meeting that he hoped the group would continue to meet on its own. In the team meeting that followed, he encouraged the staff to support the second group of female patients against the others. The staff debated whether or not such behavior should be handled by engaging in a power struggle or by attempting to understand how the two female "provocateurs" needed help with their problems. At the next ward meeting, an "in-group" developed which cut across staff-patient lines. A mock ward meeting with patients and staff reversing roles had been planned for the next day, and there was considerable anxiety over this. In its meeting the staff discussed the mock ward meeting, how close staff could really get to patients, where to draw the line, and what issues should not be discussed before patients. The following day at the ward meeting, several female patients were angry at their individual therapists and competed with each other, at the same time displacing their anger on to therapists other than their own. The chief psychiatrist got caught in a crossfire

between two female patients and turned to the male social worker for rescue. The latter picked up the discussion but then turned it over to a male patient who seemed inadequate to the task. At the same time, one of the male residents had misinterpreted a unit policy but reversed himself when the chief psychiatrist clarified the policy. In the team meeting that followed, the chief psychiatrist speculated that female patients were competing with each other for the male therapists and that in other interactions on the ward there seemed to be some evidence that male patients were undercutting and ridiculing male staff members. When one male staff member was asked what he thought about it, he indicated that he was having fantasies about losing his hair. Later, the resident who had been mistaken about the policy became quite provocative with the chief psychiatrist. In both sets of meetings the dominant theme seemed to be male adequacy.

DISCUSSION

The clinical examples given were chosen in an attempt to demonstrate how themes of formal therapeutic sessions with patients, whether in individual therapy, group therapy, or ward meetings, are often similar to the themes of the subsequent supervisory or administrative meetings such as continuous case seminars, therapy supervision, group supervision, and post-mortem staff meetings. Rather than conceptualize therapy meetings as social systems or interactions distinct and separate from supervisory meetings, it might be more useful to see the two meetings as part of a single social system, or perhaps more precisely as two *relatively* separate social systems with a person or persons common to both. The theme or conflict of one system does not cause unidirectionally a similar theme or conflict in the other, but each system mutually influences the other. The therapist can no more avoid being influenced by his interactions with his patient when he presents material for supervision than he can avoid being influenced by his supervisor's ideas and personality when he does therapy. He is not able to divorce from his mind the existence of a continuous case seminar when he is working with the patient; nor in presenting material to a seminar, is he able to avoid being influenced by the affective interactions that he experiences with the patient. Similar statements can be made about each of the other clinical

agreement. We believe the field is ripe for efforts which go beyond descriptions of technique to heuristic attempts at prescription.
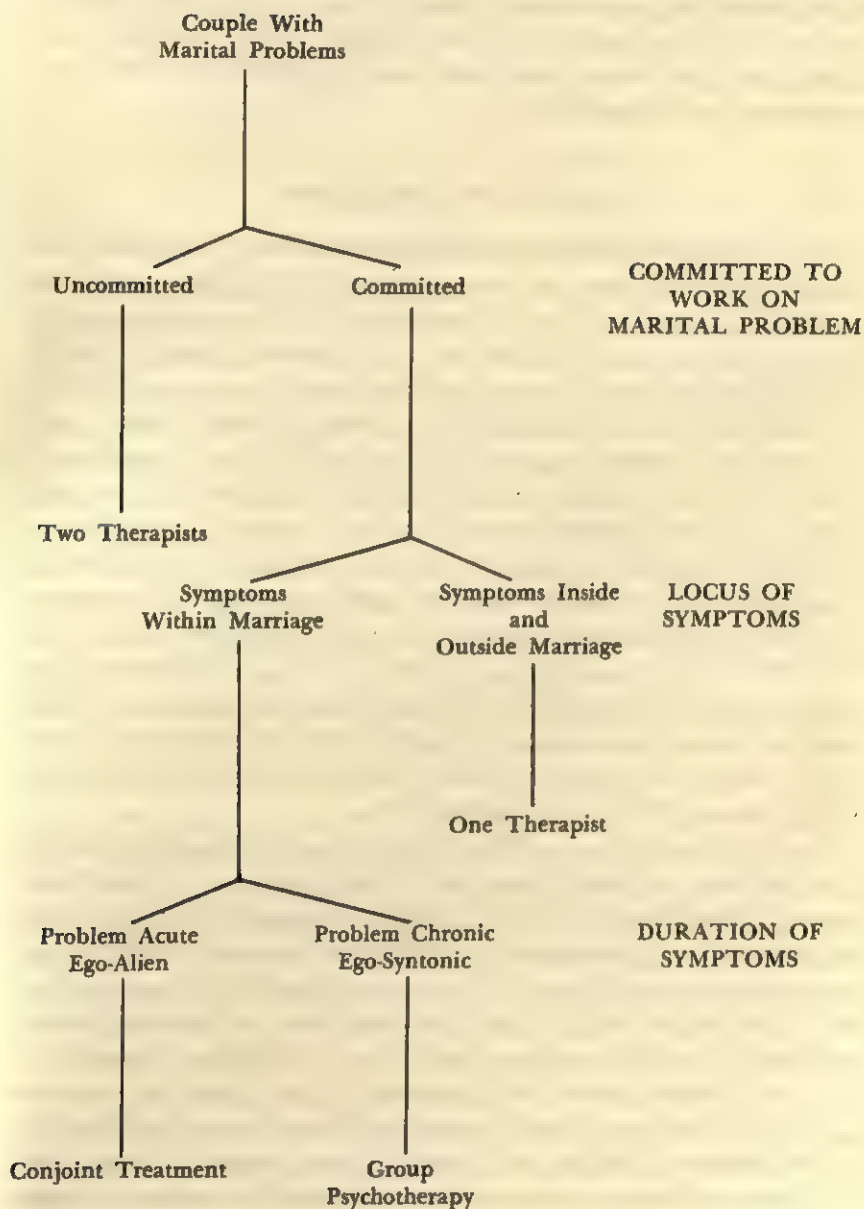
DIAGNOSTIC ASSESSMENT

In our experience, the diagnostic assessment of a couple requires both a series of interviews in which each member of the couple is seen individually and an interview in which the couple is seen together. It appears most useful to evaluate the couple together in the first interview and then separately, rather than vice versa. This minimizes the feeling that one member is making the therapeutic contract with the therapist rather than that both are doing so together.

Mrs. Wall came alone to the first interview although she had been encouraged to bring her husband when she called to make the appointment. She said, "My problem is that I cannot get pregnant and my husband's problem is that he is impotent." She also told the therapist in the initial interview that her husband secretly masturbated, and this became a major issue in their joint sessions.

Even when this precaution is taken, however, it is usual for each member of the couple to feel that it is really the other individual who is in greater need of assistance.

Greene (1966), in an important and pioneering paper, discusses the diagnostic implications of therapist factors, practical issues, and treatment prescriptions after previous failures, as well as the importance of certain dynamic issues. In his experience, suspicious, jealous, and paranoid individuals may feel initially more comfortable in conjoint therapy, while individuals with a "secret" such as inappropriate acting-out may prefer to be seen separately. He also points out that immaturity or intense feelings of sibling rivalry, such as twins have, may preclude sharing a therapist. These are obviously important problems in the choice of a therapy, especially at the beginning of treatment, but we believe these issues must be worked with so that the treatment may be selected for fundamental dynamic reasons, that is to say, a couple must learn to share, to trust each other, and to modulate their rivalry.

During the diagnostic period three parameters must be assessed and a decision made with regard to each. The first of these involves the ques-

Couple With
Marital Problems

Uncommitted — Committed — COMMITTED TO
WORK ON
MARITAL PROBLEM

Two Therapists

Symptoms — Symptoms Inside — LOCUS OF
Within Marriage — and — SYMPTOMS
Outside Marriage

One Therapist

Problem Acute — Problem Chronic — DURATION OF
Ego-Alien — Ego-Syntonic — SYMPTOMS

Conjoint Treatment — Group
Psychotherapy

tion of whether the couple's difficulties are indeed marital and the extent to which they are committed, and able, to work on them (Figure 1). The second involves an evaluation of whether the focus of perceived problems is primarily in the marriage or is more general. The third is the extent to which the problems are acute and ego-alien rather than chronic and ego-syntonic to both partners.

TREATMENT APPROACHES

The methods of treatment we shall consider are: (1) *Individual psychotherapy for each partner by two therapists*. The therapists may or may not confer regularly with each other. When they do so, and when they attempt to reconstruct and understand the important events in the life of the couple, this form of therapy has been called "stereoscopic" (Martin and Bird, 1953). On the other hand, the therapists often choose to conduct their work entirely separately as is the case in classical psychoanalysis of two married individuals. (2) *Individual psychotherapy for each partner by a single therapist,* with or without occasional conjoint meetings. This treatment was first described by Oberndorf (1938) and by Mittelman (1948), who published their experiences with the concurrent psychoanalyses of married couples. (3) *Conjoint treatment with a single therapist or with two therapists*. We believe this form of treatment was first described by Watson (1963). Haley (1963) is also a proponent of this particular treatment modality. (4) *Couples' group psychotherapy*. Treatment of couples in groups has been described by Flint and MacLennan (1962), Leichter (1962), and Papanek (1965).

If marital problems are really not a significant issue, or if the couple is uncommitted or unable to work on them but there are identifiable personal difficulties, then clearly individual treatment for one or both partners separately is indicated. If, on the other hand, both members are committed to the marriage and are able to communicate with each other, and if marital problems are significant but there are also other serious problems outside the marriage, then concurrent individual therapy with the same therapist appears to be indicated. If the couple has symptoms which are experienced almost entirely in the marriage, they should be treated together. Whether they should be seen conjointly or in group psychotherapy depends upon the extent to which the problems are acute

and ego-alien. By ego-alien, we mean the ability of each member of the couple to experience conflict about his or her role in the marriage and to recognize that he or she contributes to the difficulties. If the discomfort experienced in the marriage is both acute and ego-alien, then conjoint treatment is indicated. On the other hand, if the problems are chronic and ego-syntonic, that is to say, the problem marriage is a way of life, then psychotherapy in a couples' group is suggested.

INDIVIDUAL OR COUPLES' THERAPY

Since the patients are couples who are seeking help for their marriage, it may be asked why every married individual is not treated as though his symptoms resulted from marital difficulties. For one thing, as members of a culture in which the individual is valued, it may be difficult for patients to seek assistance for shared problems and for us to offer it. Certainly, medical training with its focus on the individual as the locus of disease does not incline us to view a marriage as a dynamic system but as two separate people each with his own symptoms. While psychiatrists may dabble in social systems theory, psychoanalysis, behavior therapy, and drug and other organic treatments are, in the main, individualistic in orientation. It may be suspected that we are all influenced to some degree by these features of our culture and profession.

Second, the procedures of psychiatric institutions often militate against a married individual receiving treatment for his marriage. In a study of the Massachusetts Mental Health Center Walk-In Clinic by Bloch et al. (1966), it was found that twenty-five per cent of all new patients came accompanied by a friend or relative. Approximately forty per cent of these, or ten per cent of the total admissions, were married patients accompanied by a spouse, but the spouse was infrequently involved in the diagnostic evaluation. Even a cursory review of the charts and a small-scale interview study showed, however, that it was usual for the problem to be marital when the patient was accompanied to the clinic by his spouse. The individualistic and medical orientation of the clinic may be judged from the fact that, until recently, when a couple came to the clinic secretary, the first staff person encountered, she asked them which one was the patient and handed that person a form to be filled out. The staffing patterns of institutions also influence whether couples and families

are seen together or individually. In the Walk-In Clinic, it is usual for the patient and any relatives to be seen by a single psychiatrist. This has fostered their being seen together more often than when a social worker is available to see relatives, as is the case on the inpatient services of the hospital. Experience previously reported (Grunebaum and Strean, 1964) suggests that one of the reasons that fathers tend to be seen less frequently than mothers in child-guidance clinics is that there is no staff person designated to see him. Thus, the structure of the treatment team, the division of responsibilities, and the professional identities involved may mitigate against or in favor of couples being seen together.

We may note in passing that there are vehement advocates of seeing all married couples together, just as there are those who believe that family treatment is the Ariadne's thread out of the maze of psychopathology. The evidence for these assertions is lacking, but those who believe we should try the new while it still works will undoubtedly do so.

Since the psychological literature on marriage offers little guidance to the clinician on how to decide when to treat a married individual as a member of a couple, what is the most appropriate course for him to follow? We would suggest that it is simply to evaluate the problem himself, that is, to interview the spouse of each married individual who seeks treatment and to interview the couple together and then on the basis of the evidence to assess the situation and the likeliest points of therapeutic leverage. If his recommendation is discussed with the couple, it is usual for them to agree; and if the subsequent course of treatment suggests that changes in the plan would be advisable, they will accept these as well.

CONTRAINDICATIONS TO MARITAL THERAPY

There are two groups of people who frequently apply or are referred as a couple for treatment for marital problems who do not in fact have primarily marital difficulties. These are, first of all, those couples in which each member appears to be rather immature and dependent and helpless, and the marital disorder is more of an expression of their mutual developmental difficulties than a marital issue per se. Often, recently married couples, such as students, fall into this category. Both partners are still deeply and neurotically involved with their own families, an

often financially dependent upon them, and are frequently legalizing an adolescent romance. They are not really ready to live in a married state. Quite often the future of such a marriage is by no means certain since it appears to offer so little mutual satisfaction. One may say that these individuals are married in name only and primarily have individual developmental difficulties.

Mr. and Mrs. Barnes, both in their early twenties and both engaged in graduate studies, had been married for two years when Mrs. Barnes consulted the clinic and requested marital therapy for their multiple problems with one another. The two spouses' past histories gave the clue to treatment. Mr. Barnes was the oldest of four sons of an ambitious mother. He had performed well until adolescence, at which time his mother divorced his father and put responsibility for the younger children on him. He reacted with stomach symptoms, but recovered his good performance upon leaving mother and family. After marriage and the birth of a child, his ability to do his academic work deteriorated.

Mrs. Barnes had a "bumbling" mother but a strong and competitive father. After her marriage she improved her already good performance to the point of being equally at ease academically and as a mother to her child, outshining her husband in all respects. The marriage problem came to be the husband's faltering in his studies, which he blamed on his wife and her demands.

The formulation was that these young people were vying with each other for their independent, active, adult roles as if there were just a certain amount of autonomy available to them, and when one succeeded the other had to fail. In individual psychotherapy, they were able to relate their present problems to their primary relationships with their parents. After a few months their marriage was restored and each spouse had matured in his own right.

A second group of couples for whom a primary focus on the marital difficulties is sometimes inappropriate is that which involves one psychotic partner. This is particularly the case in those instances in which the "well" partners come to the therapy sessions solely to be helpful to the "sick" ones and deny any personal problems. It often appears that the sicker partner is in a state of what Harry Stack Sullivan has called "vassalism."

Mr. and Mrs. Sidney were seen together by the same therapist in both conjoint and individual sessions. She was a strong person but severely

depressed and withdrawn and under the thumb of her dominant and domineering husband who "had to run things." After ten months they terminated therapy, which had been of little use. In retrospect, it was clear she had needed a therapist for herself and that her husband could not be helped to see his role in the marriage once he had used the sessions solely to talk about his wife's problems.

Kern (1967) recently discussed a case in which a psychotic, paranoid man and his pathetically dependent wife were seen together successfully. The problems of vassalism did not arise here as they were both so immature and so mutually interdependent. In general, however, it seems most useful to provide a separate therapist for the submissive individual. The tendency of the healthier appearing partner to deny, intellectualize, and avoid any commitment to working on his difficulties is usually too great to be worked through, although sometimes this can be accomplished in a group because the stronger spouses are subjected to each other's interpretations and the weaker members combine to gain strength. Often, if the initially "weaker" and more submissive partner gets better, the "healthier" and dominant partner's true pathology comes to the surface, rather as though the submissive partner has assumed this role out of an awareness that the stability of the marriage depends on it. Thus, treatment sometimes involves a decision to preserve the marriage by remaining submissive and "sick," or to continue treatment and become less submissive which often leads to divorce.

The other consideration requiring assessment is the extent to which a couple is committed to working on the marriage. A certain number of couples do not become involved in treatment once it appears that they are uncommitted to working on the marriage. One partner, usually the husband, states categorically that there are no problems with the marriage, that he is content with the way things are. His wife, on the other hand, distraught and agitated with feelings of depression and anxiety states that she is unable to live any longer with a man who is so uncommunicative. In these instances, while the husband appears more adapted, he is more rigid and less open to change, and the wife, who appears less adapted and more agitated, is in fact potentially more healthy. Frequently, in such instances, our diagnostic assessment and treatment recommendations are to no avail. The attitude of contentment and ego-centric gratification of the untroubled partner represents a degree of

mately one quarter have expressed the wish to be treated by the same therapist because so many of their friends who saw different therapists were later divorced.

In a little-known but excellent paper, Mann and Lundell (1964) discuss in detail the problems encountered in the individual treatment of spouses by different therapists. Their experience suggests the antitherapeutic influence of the following factors: (1) hierarchical problems when therapists differ in status and prestige; (2) differences in therapeutic viewpoint; (3) transference-countertransference problems often involving negative feelings toward the opposite partner and/or his therapist; (4) differences in skill; (5) differences in assessment of improvement, e.g., one therapist may regard a given behavior, such as increased self-assertion, as a positive step toward maturity, without regard to its influence on the marriage; (6) "advocate phenomena," i.e., in discussions between the therapists, there is a natural tendency to take sides; (7) practical as well as emotional impediments to adequate communication between the therapists. The experience and conclusions of Mann and Lundell are much like our own, namely, that when the focus of treatment is the marriage, it should be carried out by a single therapist, all other things being equal.

It must be emphasized at this point that a singularly important consideration in the choice of therapy pertains to the abilities and needs of the therapist. If the therapist imagines himself dealing with immature individuals in a setting in which he first sees one and then the other of the spouses, or if he imagines how it will be to work with them together, he may well say to himself, "The two of them are just too much for me." Indeed, a therapist may be wise, depending on his inclinations, not to become involved in treatment of two spouses whose conflicts are so intense or whose involvement with each other lacks any distance that the therapist feels overburdened. The forms of treatment to be described cannot be practiced comfortably by inexperienced therapists, and it may be useful for inexperienced or unmarried therapists to use stereoscopic approaches, such as those advocated by Martin and Bird (1953), as a way of learning to deal with a couple.

In summary, we may say that separate treatment of married couples is indicated when (1) the marriage does not appear to be the problem of greatest priority and when either maturational issues or severe psycho-

pathology in one partner is crucial; or (2) the couple appears uncommitted to the marriage or to working out their marital difficulties. Furthermore, this form of treatment is often necessary because of the inclination or inexperience of the therapist.

CONCURRENT PSYCHOTHERAPY

Falling between those patients for whom marital problems appear almost irrelevant or who have no commitment to working on their marriage and those who see their problems as stemming solely from the marriage are a large number of couples who experience difficulties both within and outside their marriages. In these instances, we believe, concurrent psychotherapy by a single therapist is most useful. This treatment technique was discussed most recently by Grinker (1966) who focused on some of the advantages and problems. He noted that distortions are diminished, reality testing is fostered, and affect may be increased and acting out diminished. On the other hand, the transference may be overly intense, involving oedipal and rivalrous feelings.

The essence of concurrent psychotherapy is that it is individual psychotherapy of two people who are closely related. This method is like psychotherapy in that it works best with patients with clear-cut neurotic problems, those individuals who can develop and resolve the transference and make use of clarification and insight. Patients with characterological problems who do not develop a workable transference neurosis and those who neurotically blame others for their problems will have difficulty in individual psychotherapy and concurrent psychotherapy alike.

The advantage of concurrent psychotherapy when the couple complains of problems both within and outside of their marriage is that it permits the therapist a much more satisfactory position for assessing the real situation of each partner. Since disputed differences between the partners are related by each, the therapist hearing both sides is less likely to misjudge the situation. For this reason, concurrent psychotherapy is less divisive of marriages than is treatment by two therapists. When both partners are seen, overidentification with either of them is minimized and countertransference is more easily mastered. The realistic view of marital problems presented, together with the opportunity to do individual psychotherapy, constitutes the unique advantage of concurrent

psychotherapy. It constitutes, in our opinion, the most economical method for the effective treatment of the intramarital and nonmarital neurotic problems of married couples. An example will illustrate a typical case.

Mr. and Mrs. Rivers complained of difficulties in their marriage. An evaluation disclosed that Mrs. Rivers had had lifelong phobias, which kept her somewhat confined to the house. She was excessively dependent upon her husband but could not deal with her anger toward him save by sullen withdrawal. Mr. Rivers, on the other hand, was a man of violent temper who flew into rages at the slightest provocation and was particularly sensitive to his wife's emotional withdrawal, which he handled by excessive drinking. They were a bright, college-educated pair who had studied a good deal of psychology and communicated well with each other. As they explained their difficulties, it appeared that Mrs. Rivers' phobias and Mr. Rivers' temper tantrums, which had caused him to be fired from several jobs, were problems both within and outside the marriage. Each appeared to recognize that his problems had neurotic origins from his childhood and each was eager to work on these problems. The decision was made to see them concurrently since it did not appear that the problems were of recent origin but, rather, had existed for the duration of the marriage and that each was willing and able to work in intensive psychotherapy. During the course of therapy they were able to resolve their neurotic problems and improve their marriage greatly.

To the extent that married partners blame each other, there will be difficulties with this technique. If the blame is neurotically determined, sometimes this can be brought in to the therapy and internalized. Often, however, this cannot be done easily as the blame is in part justified. Thus, a therapist will find himself hard-pressed to tell a wife that she is overreacting when she becomes depressed because her husband fails to express any enthusiasm over her graduation from college. The therapist may well agree with the wife that her complaint is justified. How is he now to deal with this problem in his treatment of the husband? He cannot with impunity violate the confidences of the wife and say to the husband, "I hear you're not interested in your wife's graduation." The husband may reply, "I just got back from a three-day conference which was crucial to my career." Direct use of material from one individual's therapy in another's tends to put the therapist in the position of taking sides and is experienced by each partner as an accusation. It also conflicts with most therapists' feelings about confidentiality. It thus appears that

concurrent psychotherapy is most useful when each spouse recognizes that his problems with his partner are a significant but not sole source of difficulties and when communication between the partners is adequate.

CONJOINT TREATMENT

If the couple experiences problems as arising primarily within the marriage, the next diagnostic decision is the extent to which the problems are acute and ego-alien. If the marriage, although troubled, is one to which both partners are committed, and if the difficulties are acute, conjoint treatment is indicated. It makes little difference whether the difficulties stem from the entry of a child into the family, from the imminent departure of a grown child from the family, or from major changes in job, living area, etc. When couples come with high anxiety, with a clear bilateral recognition that something has recently gone wrong in their marriage, and with a feeling of, "We need to get back to where we were," conjoint treatment is indicated. The diagnostician gains from the interview the impression that the marriage involves genuine caring and concern of the couple for each other. If the couple comes to the diagnostic interview blaming each other, what is vital is that this blame should be of recent origin, that is, that the partners say something to the effect of, "Things were all right until you changed jobs," or "until the baby was born." If blame is chronic, conjoint treatment is rarely useful.

An example of the indications for, and successful use of, conjoint treatment is that of Mr. and Mrs. Douglas.

Mr. Douglas, a man many years older than his wife, had successfully completed a psychoanalysis some years prior to their marriage. He was now looking forward to accepting a new position out of state. Mrs. Douglas was graduating from college and had just stopped contraceptive measures so that they might have a child. Both of the Douglases came to therapy because they had noted that their sexual relationship and their marriage in general had deteriorated markedly since they had ceased using birth control, and both recognized that the fear of having a child was somehow involved in their difficulties. In a two-month series of interviews, they were seen together, with the entire focus on this recent problem. Mr. Douglas made numerous efforts to talk about his severe childhood deprivations, but these were dealt with as his way of asking to be mothered by his young wife and his inability to assume paternal

responsibilities. Mrs. Douglas, on the other hand, tended to have frequent fantasies of inappropriate extramarital relationships, which her husband questioned her about endlessly. They were dealt with as her fear of growing up and assuming maternal responsibilities. In a series of ten interviews, the couple reported rapid improvement in their sexual relationship. Although their difficulties could be understood as the outgrowth of patterns established in childhood and each had certain symptoms outside the marriage, it was clear that they were committed to life with each other and that their problems were primarily inside the marriage and acute.

COUPLES' GROUP PSYCHOTHERAPY

When, on the other hand, the evaluation of a couple demonstrates that the problems are both chronic and ego-syntonic, that is to say, that the problem marriage is a way of life, then group psychotherapy is most useful. It is usual in our experience that couples who do well only in groups have problems which are primarily experienced as within the marriage and that blame for these problems is often focused on the other marital partner. It is also usual that the couple does not have a period to look back on when the marriage itself was happier—certainly not in the recent past, although occasionally we have noted that such couples state that before they got married, things were better.

Couples' group psychotherapy offers certain special advantages. First, the couple can gain some objective evaluation of their problem. If everyone agrees that Mr. Aran should not yell at his wife nor beat her, the consensus can be helpful. However, it may be even more useful when the group points out that the long-suffering Mrs. Aran provokes those attacks. Second, the strong members can make interpretations of each other's problems which are accepted because of mutual respect. Third, the weaker members are natural allies so that the leader does not have to defend them.

Jones (1967) has noted that certain couples can gain perspective only in a group because, in conjoint sessions, they engage in "issue hashing," with mutual attacks and defenses. Jones feels, as do we, that an indication for group treatment is "the chronic interlocking of their mutual regressions" with "compromise adjustment." The couple is together "not because they want to be but because they must be."

In our experience, groups often work most satisfactorily when the

member couples have problems at a similar developmental level. We have delineated two types of couples who do best in group psychotherapy. One such type is exemplified by the following case:

Mr. and Mrs. Xavier had been married seven years and had two children, but over the years since their courtship things had gotten steadily worse as Mr. Xavier became increasingly successful. He was a physicist and chess player who took his work home. She complained of many psychosomatic ailments, and she resented her children, whom she was yelling at and hitting increasingly often. This behavior of hers led Mr. Xavier to withdraw further into his work. In the group, Mr. Xavier was able to help Mr. Varax, who was a traveling salesman, and in turn to learn from him. For her part, Mrs. Xavier gradually learned that a husband was not a mother and that with the help of babysitters she could do much more with her life on her own. They terminated treatment after two years and much improvement.

Such couples tend to be fairly healthy individuals, and while some have neurotic traits, they have developed socially adaptive means of coping with their character problems. Both partners usually have had reasonably healthy premarital adaptations, the women having been able to separate from their families and the men to become successful in the world. Often the marital difficulties begin between the fifth and tenth year of the marriage when the woman is confined to her home by her children and the man is led away from it by his success. These couples often appear to fit the classification of the lovesick wife and the cold-sick husband, that is, the women complain of feelings of loneliness, isolation, and lack of fulfillment, and the men have tended to use intellectual pursuits and intellectualization as a substitute for emotional closeness. We have found these couples particularly suitable for group work in that cross-couple interpretations appear to carry weight because the members recognize each other as similar in intellectual level and insight.

There is another group of couples who appear to do about as well in group treatment as they do poorly in general. These couples have been married much longer (usually more than 15 years) and the marriage problems are chronic. The nature of the couple's interaction is surely pathological. Most of these couples have children at least in adolescence or grown children who have left home. It often appears that as long as the children were young, gratification could be obtained from them; thus,

the focus was kept away from the partner. Because of their characterological difficulties, few of these individuals have had much success in life. Frequently, members of such couples are addicted to food, alcohol, or gambling. Individual psychotherapy or casework has usually been of little avail although often continued for years because of the gratification provided. The stability of these marriages has depended upon the maintenance of distance between the partners, and new demands for mutual involvement lead to anxiety and further distancing maneuvers.

Mr. Shore came to the clinic saying his wife of eighteen years was leaving him. They were asked to come for a joint interview when it became clear that, although both said only the love of their children had held them together, they were locked together by chains of hostility and dependency. He was a gambler and taxi-cab driver who drank. She was a long-suffering woman who had ignored her husband for the children and was frigid. A referral to group was made and after three years some progress was noted.

Such couples require prolonged, arduous group psychotherapy, and drop-outs often occur when the possibility of change appears real. It is in these couples that mutual recrimination is especially prominent.

Thus far in this paper, we have discussed diagnostic assessment and the indications for the treatment of troubled marriages. But it is clear that the impaired functioning of any given couple may be viewed in terms of a hierarchy of problems, and the solution of problems may require different therapeutic settings and goals.

Mr. and Mrs. Staple were quite happy until she graduated from nursing school and began to support her husband and his education. At this point, arguments commenced and he increasingly withdrew into his work, claiming that although he loved his wife, she had turned into a shrew. Discussion with her suggested that since beginning work, which she recognized was vital to their future, she had felt increasingly like a slave. This feeling was closely related to the fact that her mother had always had to work to support her imaginative but unsuccessful father. In view of the fact that her neurotic problems had been exacerbated by the recent change from student to worker, it was recommended that she be seen in individual treatment and that the couple be seen together to evaluate his less available fears of closeness. As was predictable, as she recognized her difficulty she became less unhappy and began to make increasingly

realistic and affectionate rather than argumentative and belligerent demands upon her husband for closeness. When this occurred, his need to withdraw into his work and his difficulties in responding to her closeness began to emerge. Thus, at this point, they were seen together and he was seen individually.

SUMMARY

We have discussed a basic diagnostic framework for marital therapy and given case examples. It has been suggested that the couple be seen separately when the partners are uncommitted to work on their marriage or when marital problems appear to be secondary to immaturity or severe pathology. When the couple is committed to the marriage, able to communicate with each other, and problems are experienced both within and outside the marriage, they should be seen concurrently. When the couple is committed to the marriage and the symptoms relate almost entirely to the marriage, they should be treated together. If the problems are acute and ego-alien, then conjoint treatment is indicated, whereas if problems are chronic and ego-syntonic, then couples' group psychotherapy is recommended.

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A Confrontation Technique Used with
Married Couples in a Group Therapy Setting

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PATIENTS WITH NEUROTIC PATTERNS usually reflect these patterns in their marriage. With progress in therapy, the marital balance often changes and the other spouse may well seek access to and later treatment from the same therapist. In the past, many psychoanalytically oriented individual psychotherapists obeyed Freud's (1912) technical advice not to engage in concomitant activity with relatives of the original patient. However, in the past quarter of a century, it has been demonstrated that, despite certain technical difficulties within the therapy, one therapist can treat husband and wife simultaneously (Mittelman, 1944, 1948, 1956).

This paper will attempt to delineate a technical approach that can be used with a solo patient who is started in individual therapy and later transferred to group therapy and whose spouse, at some point in this process, requests treatment for his own individual neurosis and to correct the neurotic patterns within the marriage. In this approach, both partners are seen by the same therapist throughout, with therapy starting separately but concluding in a simultaneous, shared group experience in which the couple are the only associated pair in the group situation. Although this technique has been used with several couples, the experience with one couple will be described in depth in the belief that such a description will more accurately reflect the nature of the technique.

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CLINICAL MATERIAL

Mr. P., when first seen in consultation, was 31 years of age. He had been married for nine years to a wife four years younger than himself, and they had one daughter aged three. Although Mr. P. came from impoverished rural stock, he had graduated from college, and was employed at a local concern as a foreman in charge of a machine section. He had not pursued a career in biology, as he had once planned to do, because his family, with inverted snobbism, had rejected him for his pursuit of higher education.

Mr. P.'s chief presenting complaint was a crawling sensation in his face which had begun three months prior to psychiatric referral. The sensation was initiated by excitement and ultimately encompassed such other complaints as occipital and cervical pain, paresthesias affecting the skin of the face, arms and hands, with weakness of the left arm, left leg, and both knees. The attacks had increased in frequency and severity and had become associated with a sense of fatigue and mild depression.

He had consulted several physicians, including a neurologist, who declared him to be physically healthy and recommended that he be seen by a psychiatrist. He accepted psychiatric consultation reluctantly and mainly because he felt denied further physical investigation and treatment. It was with a sense of forlornness and desperation that he presented himself for the psychiatric consultation, for he was convinced that he had a real physical illness of some severity that had been missed by the physicians.

Psychiatric examination revealed the presence of an anxiety state with mild depressive overtones in a man whose personality reflected marked dependency needs, which were denied, together with inhibition of his aggressive drives. While not schizoid, he displayed an isolation of affect toward those relatives nearest to him, and he verbalized concern over his lack of warm feelings for his daughter. This isolation of feeling had been present from early adolescence.

In outlining his complaints, the patient utilized the defenses of repression, suppression, and denial and was particularly rejecting of any possible association between current life events and his physical difficulties. He specifically denied any evidence of marital, personal, or work

difficulties, insisting that his only problems related to his physical symptoms. It later transpired that he had accepted psychiatric referral only to humor his internists whom he hoped would undertake further physical studies after a negative psychiatric report. His psychiatric state seemed compatible with a diagnosis of anxiety reaction, with hyperventilation episodes accounting for all of his physical complaints with the exception of headaches. The neurologist considered the headaches to be secondary to tension. In view of the patient's lack of motivation for psychotherapy and his reluctance to return for further interviews, it was suggested that he be treated psychopharmacotherapeutically and he was returned to the care of the referring physician.

Within three months, Mr. P. was seen again at the request of the neurologist. His affective and somatic disturbances had improved with psychotropic medication, but his headaches were now more severe. These tension headaches seemed to be related to a dawning awareness that his complaints were not of physical origin. He still did not present himself as a suitable candidate for psychotherapy, but it was obvious that he needed reassurance that psychological disturbances could influence the body; also, he needed to be seen for regulation of drug dosage.

The author has for several years seen such patients in a twice-monthly group counseling situation. This group functions mainly in a supportive way, and although insight is obtainable, it is usually limited by the group structure and resistances. Larry attended ten sessions of this group and benefited from no longer feeling alone in his attitude toward his complaints. He developed a rapport with the therapist which later blossomed into a positive transference colored with magical expectations that compliance to the therapist's wishes would result in complete subsidence of his symptoms. He saw in others how life events were reflected in physical symptoms, and he acknowledged that a similar process could occur with him. This reversal of attitude concerning his physical state seemed to be based upon compliance rather than a true corrective emotional experience, for at later stages of his therapy, with life reversals, his old doubts about the psychogenesis of his symptoms would return.

After six months, all therapy was interrupted for the summer recess. In the fall the wife first made her appearance. Previously, she had stayed in the background, taking the stance of a nonparticipant observer. By

now, Mr. P. had admitted that his marriage was in difficulty but accepted all the blame, stating that it was his lack of warmth that was responsible for this state of affairs.

The wife revealed that prior to Mr. P.'s attendance at the counseling group, she had had little faith in psychiatric treatment and was quite rejecting emotionally to her husband for his need for this experience. She readily conceded that she had initially been attracted to Mr. P. because he offered an opportunity to escape from the unhappy confines of her parents' home. She found, too, that his emotional detachment made few demands upon her; she also had the same isolation of feeling from those around her and presented a cold, aloof manner to friend and foe alike. Within the first two years of marriage, she had been unfaithful to Mr. P. over a period of several months and was hurt by his ignoring the whole situation even though she clearly signaled that she was having an affair. Shortly after the affair terminated, she found herself pregnant by her husband and had been faithful to him ever since. With the birth of their daughter, she desired a warm and loving environment for the child and had tried to pressure her husband into providing such an atmosphere for the child and herself. This pressure seemed to be one of the principal factors creating the surge of symptoms in Mr. P. at the time of the initial consultation nine months previously. An additional pressure came from Mr. P.'s father who wished his son to invest his money in farmland and to return to the family occupation of farming.

Mrs. P. was quite willing to see the therapist in conjoint sessions with her husband but it was mainly to correct distortions in her husband's perception of events. She seemed not to desire change in herself, only change in the environment for the child. She said that she was willing to try to improve her interactions with her husband, but she made it clear that it would have to be by his direction and not spontaneously from her.

In both partners, there was a preconscious wish for warmth, affection, and trust from the other, yet both defended against these wishes by a reaction formation of withdrawal, aloofness, and a defensiveness against trusting the other. Not surprisingly, the child was aware of these feelings and was herself beginning to react negatively to her parents, a situation which compounded both parents' distress. A recommendation was made that both partners enter group psychotherapy of an intensive psycho-

analytic nature. They agreed, but only with the proviso that they be in separate groups, for both feared that open hostilities might emerge which would threaten the marriage. Mr. P. began his treatment, but Mrs. P. decided subsequent to the conjoint session that to need any therapy was to be weak and that she would not avail herself of the opportunity.

Mr. P. did well in the new group, which was a closed group of patients with moderately severe neurotic patterns meeting once weekly for ninety minutes. All of the members were from an upper socioeconomic level and had much more sophistication in psychological and interpersonal matters than did the members of the old group. As Mr. P. participated more and was accepted by the group, his physical complaints subsided. He began to report more assertiveness in his job and with his parents, but not with his wife. An unexpected job promotion awarded to him because of his assertiveness and initiative did not cause a recrudescence of his symptoms, as might have been expected.

After three months with his new group, the couple were seen together at Mr. P.'s request. He wished to have the therapist reduce the wife's demands that he demonstrate more of his new-found strength toward her and not just toward his work and their child. The confrontation sessions then and later in the spring highlighted the fact that Mr. P. was able to give more emotional warmth than before and that Mrs. P. was now isolated in that she was still hampered by her own coldness and noninvolvement in the marriage. Mrs. P. began to be increasingly depressed. She then learned that the author was starting a short-term, intensive, analytically oriented group psychotherapeutic experience for several patients from the university who were ready for a group experience but who would be dispersing for the summer. She requested and was admitted to the group, where she participated fully, and this was reflected in a more trusting and warmer reaction to her environment.

At this point, a crisis occurred, for now both partners were more than ready for a major and consistent commitment to their marriage but each attempt they made was short-lived and not fully successful. They lacked the capacity to discuss their differences together, even though both had, in effect, surrendered themselves to others in the group experience and had discussed their difficulties. Each group urged the particular partner to make the commitment, but both partners hesitated. In their conjoint

sessions, which occurred at five-week intervals, each partner spoke of the wish, yet neither would make the first move.

The stalemate was broken by Mr. P.'s increasing withdrawal into silence and sullenness in his group, which later developed into frank and outright distortion of home events and outside occurrences. The author, as the therapist to both partners, was directly aware of Mr. P.'s distortions but hesitated to use information which had been learned in an individual or conjoint session and which, if used, might create negative feelings within the group and interfere with the group dynamics. Confrontations in principle were made in the presence of the group but without revealing intimate details. These were less than effective and aroused the curiosity of the group and created negative feeling toward Mr. P. for his self-defeating attitude. Mr. P.'s defiance and wish for punishment led to further withdrawal. The author did not feel that a more direct confrontation could be made under these circumstances without evoking negative feelings among the other patients and without running the risk that Mr. P. would withdraw from all treatment.

It was at this point that the individual groups in which Mr. and Mrs. P. were participating made the suggestion separately and spontaneously that Mrs. P. be invited to sit in as a guest with Mr. P.'s group so that direct confrontation could take place in the presence of Mr. P.'s group. The transfer of Mrs. P. was suggested initially because her group would soon be terminating. Since the author had used this technique with other couples with good effect, no veto was exercised and Mrs. P. attended Mr. P.'s group. In the two meetings remaining before the second summer recess, the group addressed itself to the marital problems of the couple. Each partner felt obligated to be honest in the presence of the other. Mr. P.'s group was accepting of Mrs. P. and were pleased by the confrontation. At the conclusion of the second meeting, the group made the recommendation that Mrs. P. stay with them in the fall when the group reconvened. By now eighteen months had elapsed.

From the next October through the following May, Mr. and Mrs. P. were the only married couple in Mr. P.'s group. Mrs. P. was quite inactive verbally, but her presence served to strengthen Mr. P.'s participation. She encouraged him nonverbally when it was apparent that he was functioning as an integral member of the group and was silently but clearly disapproving when he would evince evidence of the wish to withdraw.

She did not bring up domestic situations but she did offer supplemental and clarifying comments when Mr. P. spoke of them. When Mr. P. fell back on his old pattern of distortion and withdrawal, Mrs. P. supplied omitted details. This would be followed by a group working through of the situation. There was a mutual reinforcement factor in that the couple would continue to analyze the group's responses to them and their situation after they left a session. In addition, their working through of their marital difficulties in the group setting provided for the first time in their marriage a close shared experience. Conjoint sessions were held on infrequent occasions at the request of the couple and only to break a continuing stalemate. At such conjoint sessions, the therapist could refer to his observation of their interaction in the joint group experience.

Both patients, with the approval of the group, the therapist, and themselves, terminated treatment some thirty months after the initial contact. They had overcome their communication difficulties and had learned the extent of their positive and negative feelings for each other. They had developed a responsible interdependence upon each other, and there was a closeness and warmth between the patients and their daughter that had not existed before. At work, Mr. P. received increasing recognition, and he successfully separated himself from the cultural prejudices of his family, primarily at the instigation of the group but also because his dependency needs were met in growing measure by his wife and he could relinquish his yearning for these to be fulfilled by his father. His wife now feels that she can trust and rely upon her husband, and her respect for him is increased in that she has seen his acceptance by a group of people whom she respects for their achievements in life. More importantly, Mr. P. can now give her the tranquility of knowing that she is loved by her husband.

DISCUSSION

In this case, the initial patient, Mr. P., was not seen as a suitable candidate for any form of psychotherapy. Indeed, had the suggestion been made by the therapist, it would have been declined by the patient. Three factors led to Mr. P.'s decision to return for further advice: the partial success of the psychotropic medication in diminishing his anxiety and depression, the failure of the physical symptoms to disappear, and the

continuing disinclination of his physician to pursue a pathophysiological basis for his headaches.

For Mr. P., there was a gap between the supportive group which he would quickly outgrow and the more sophisticated, analytically oriented group which he could not accept. It was obvious that his dependency needs would not be met in the unstructured environment of the second group, and yet he needed the emotional experience and insight that it alone could offer. He lacked self-support for his initial therapeutic endeavor, and his wife not only did not provide extratherapeutic support but was hostile to his need for psychiatric treatment. However, the supportive group experience provided an essential bridge to the more advanced treatment by allowing him some insight into the interaction between his life difficulties and somatic discomforts. The author believes it to be an advantage to have groups of differing levels of sophistication, with periodic shifting of patients at appropriate intervals.

Mr. P.'s improvement made Mrs. P. aware of her inadequacy and placed upon her the responsibility for meeting Mr. P. in a more positive communication experience. She rejected the therapist's advice to join a new group with Mr. P. for two apparent reasons: the neurotic fear that arguments of a hostile nature would develop in the group and lead to a dissolution of the marriage, and, secondly, the conjoint sessions were just helpful enough to allay her anxiety and so diminish her wish for change. Mr. P.'s improvement over the nine months of the insight group, however, revived her anxiety and led to her subsequent request for a separate group experience. As had been true for Mr. P., this initial group prepared her emotionally for the more intensive experience which she later had when she transferred to Mr. P.'s group. It should be noted that Mrs. P. had met her husband with their car after several of his earlier sessions and had had the experience of hearing patients discuss their gains from group therapy; also, intuitively, she was aware of friendly feelings toward her and her husband by the other group members. When she began her own group therapy, she wanted to succeed and made an honest and full commitment to the group process.

As she rapidly improved in her ability to communicate and show warmth, Mr. P. began to deteriorate and demonstrated his pattern of withdrawal, omission, and distortion within his group; as Kohl (1962) has described, this is a common phenomena occurring within a marriage

when both partners are in therapy. For some time, the author has followed the practice of using selected information gained from individual or conjoint sessions in confrontation of a patient within the group at times when the patient is not willing to discuss a conscious concern with the group. There has been little difficulty and much gain from this approach. But Mr. P.'s omissions and distortions were so gross and his negativism so profound as to cause him to ignore or deny the therapist's hints about his withheld information. This led to frustration and anger among the other group members, who could see Mr. P.'s withdrawal but could not help him deal with its causes. The causes usually involved family interactions which could and should be discussed within the group setting, but Mr. P. was defiant to the point of denying the validity of the therapist's observations. To overcome the denial by the therapist's citing chapter and verse would have been unseemly and would probably have aroused resentment and anxiety in the other group members. Yet, Mr. P. was clearly heading in the direction of a full-blown depression and a recurrence of psychosomatic illness. Total rejection of all psychotherapy, and even of his marriage, seemed to be in the offing.

It is in such circumstances that the author advocates the practice of arranging a confrontation experience in a group setting. The question may be asked why such a confrontation should not occur in the conjoint family session. Both Mr. and Mrs. P. had made such solid gains from the group experience that it was the author's belief that they would benefit most from continuing group psychotherapy. Mr. P. had previously demonstrated a reluctance to discuss in the group certain painful awarenesses gained in conjoint sessions, and his negativism was so great that this seemed certain to happen again, even if he continued to attend the group. Therefore, it seemed potentially the best course to have the wife join the husband in his group for the confrontation experience.

Mrs. P.'s own group experience allowed her to blend successfully into the group, and her pattern of participation in her husband's group loaned him strength. Acting as an auxiliary ego for him, she gave him nonverbal encouragement, only making confrontations at moments of crises when it was obvious that Mr. P.'s negativism was re-emerging.

The therapist and the group members perceived her presence as nonthreatening and supportive for Mr. P. This evoked warmth to her, which further encouraged her self-esteem and her patterns of behavior. The

absence of other couples made them special in the eyes of the group. In working through the marital problems of this couple, the group members emulated the advice given in their own marital experiences. The presence of the marital couple thus served as a catalyst in deepening the group's understanding of marital dynamics. When Mr. and Mrs. P. were experiencing difficulties together, the pain of their experience led to the emergence of repressed childhood material from other group members, which again was beneficial to the over-all progress in the group. It is the author's belief that this is less likely to occur if all the patients in the group have their spouses present, for the focus is then more on present difficulties.

An appraisal of this approach must also include the effects on the therapist of this pattern of therapies. The possibility of the therapist consistently missing the correct emphasis in the material, or siding with one spouse, or being bothered by intense countertransference feelings seems much less when the confrontation takes place in the group setting following the transfer of one spouse to the other's group. The possibility of the group members making the same errors would also seem to be less. With one therapist being the possessor of all the information within the marital interaction, the difficulties that may arise when there are separate therapists communicating or siding with their respective patients do not occur.

This confrontation technique need not follow the pattern of a permanent transfer of one partner to the other's group but may be carried out with visits by one or both partners to the other's group depending on the circumstances in each case. Difficulties can, of course, arise if the timing of the visits is injudicious or the exchange of the patients unwise.

SUMMARY

The author sees marital members in a triad of individual, conjoint, and separate group psychotherapeutic modalities. A major resistance by patients is to withhold from the group experience information brought out in the individual or conjoint sessions. A solution that has facilitated therapy has been to allow spouses to visit each other's groups so that the marital and individual psychopathology can be interpreted in the favorable group climate.

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The Exchange of Tape Recordings as a Catalyst in Group Psychotherapy with Sex Offenders

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This paper describes a relatively novel use of anonymous tape exchanges between therapy groups. This maneuver would appear to be of value in enriching the group composition in various settings which impose limitations on patient selection. In addition, in the present work, several quite unexpected patient reactions to this approach indicate benefits reaching far beyond the simple improvement in group composition. These reactions appear to have specific implications for the treatment of sex offenders and general implications for brief, intensive group psychotherapy with a broader range of patients. It is also conceivable that such a technique may be of use in individual psychotherapy at times when a specific type of confrontation is desired in the course of treatment.

The tape exchange to be described was initially devised as a partial remedy for some of the practical limitations of conducting psychotherapy in a single-sex institution. The intent was to provide a sex education experience, albeit a superficial one, which would circumvent some of the intense authority problems in the sex offender group while at the same time encouraging greater emotional involvement because of the inclusion of real people in something at least approaching a genuine life situation.

The primary therapy group consisted of five sex offenders being

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treated on an in-patient basis at the Sex Crimes Facility at the Wisconsin State Prison. Before, during, and after the tape exchange experience, the group received biweekly group psychotherapy as provided by the Wisconsin Sex Crimes Law. This law and the program which has developed from it have been described elsewhere (Halleck and Pacht, 1960; Uehling, 1962; Pacht et al., 1962a, 1962b; Roberts and Pacht, 1965; Pacht and Roberts, 1968). The sex crimes group included three men about 30 years of age, one in his 50's, and one 62-year-old male. Their offenses included forcible rape, sexual perversion, and indecent liberties with minors.

The members of this group were asked if they would agree to being addressed (through a tape recording) by a group of university students. They understood that they had the option of replying to the tape if they wished. All members agreed to listen to the student tape, and all agreed to reply after having heard it. The stipulation was made that care must be taken to conceal the identity of the members of each group from the other group, a precaution that was a condition of administrative approval of the program.

The student group was recruited through announcements to students taking a course in introductory psychology. Five women expressed interest, and one male also joined the group. The student group ranged in age from 18 to 33. Because of the method of recruitment, the group included members with obvious sexual problems. One female member had a problem with promiscuity, another with struggling to implement a rather atypical, though apparently well-articulated, sexual philosophy, and most of the other evidenced general concerns in the sexual area that were troublesome to them as individuals.

The student group was begun as a "discussion group" and given the topic of premarital sex to discuss during the first meeting. They were instructed, however, to rely on their own personal experiences and feelings rather than to attempt an abstract or scholarly discussion of the subject. Each of the members of the student group seemed to accept the program as an exchange rather than an arrangement in which the student group would "instruct" or "help" the sex crimes group. Not surprisingly, the student group quickly (even rather impatiently) developed into a brief therapy group, and after the first meeting, none of the subsequent meetings required an agenda. There were eight student tapes and seven sex crimes group replies, although after the first exchange, it would be

incorrect to describe either the student or the sex crimes group tapes simply as "replies." The sessions of the student group were limited by the termination of the semester. First names or nicknames were used in both groups to preserve anonymity. The location of the university group was not disclosed, and members of the sex crimes group were careful not to identify their home communities. Although the anonymity requirement was initially greeted with pleasure and relief, both the sex crimes and the student groups began to express some annoyance with these restrictions toward the end of the tape exchanges.

Almost immediately, both groups adopted the technique of taking notes on the content of the tape addressed to them and withholding reaction until the end of the tape. This delay in response made the tape sessions much more controlled and formal, of course, than the typical and natural interaction of the separate groups.

Two illustrations of the type of interaction considered therapeutic may be of interest here. One of the members of the sex crimes group— let us call him John—had been troubled by his wife's turning to her father during periods when the couple was in economic distress. Apparently, the money problem was never severe, and John felt that his wife was expressing a lack of confidence in his ability to provide and subverting his manhood by her rather frequent appeals to her father. He had made his feelings known to his wife and even discussed the matter briefly with his father-in-law. However, the situation continued without change.

The student group reflected that, very likely, the father-in-law was actively facilitating his daughter's behavior in the situation. Pointing out that John had cohabited with his wife during a considerable period before their marriage, they speculated that the father might be intensely angry and could well be expressing his anger indirectly in this fashion. This interpretation made a great deal of sense to John, and it also led him to see how he expected immediately to be forgiven for his behavior on the grounds that he was well-intentioned and eventually "did the right thing." John's strenuous efforts to avoid responsibility for his own actions had already been a topic of considerable discussion in the group sessions which preceded and paralleled the tape-exchange sessions. However, hearing this same idea discussed by individuals so far-removed from his situation had an unusually strong and sobering effect on him.

The second illustration concerns a female member of the student

group—let us call her June—who recounted a rather lengthy and detailed dating relationship with a young man. Initially, her encounters with him had been intense and romantic, but she had gradually drifted into a relationship in which she felt rather motherly toward him and he sought her out mainly for advice and guidance. In discussing this relationship, members of the sex crimes group guessed (correctly) that June had engaged in sexual relations with this young man. They then speculated that she was now continuing a relationship upon which she placed no value with a young man whom she had outgrown emotionally. Apparently, they speculated, June was continuing the relationship as a "mature" and "giving" individual in order to expiate guilt feelings over the premarital sexual contact. While the tape was being played, June stared fixedly at the tape-recording machine, apparently unable to believe that she had been "found out" in this rather complicated and indirect manner.

After her initial disbelief and upset, June did admit the accuracy of the speculations regarding her premarital sexual contact. The accompanying insights made sense to her also, and she seemed to gain perspective and relief from neurotic guilt feelings as a result of the confrontation. There were several other examples of this type which could be recounted. However, perhaps the point is made that rather deep emotional involvements were present.

OBSERVATIONS

No formal evaluation of this approach was planned in view of the uniqueness of the two groups and the small number of sessions involved. Nevertheless, some rather trenchant, meaningful, and probably useful results were clearly observable:

1. There was considerable progress toward emotional acceptance of sexual and sociosexual differences between men and women, although it is admittedly difficult to judge the depth of the changes observed. The material involved consisted mainly, but not exclusively, of insights which the patients had already at least partially understood intellectually. However, the effect on actual behavior and attitudes of this "understanding" had been minimal in the case of most members of both groups.

There were also some areas in which either or both groups had not yet achieved a clear understanding even on an intellectual level. For exam-

ple, the male's greater ability to be sexually aroused at a distance and by psychological means seemed to have implications which surprised both groups as it came out in the interchange. Also, the somewhat greater urgency of the male sexual response, at least in the initial stages of sexual excitement, had not been clearly understood. Most of the males and females in both groups seemed to have been attempting to imagine the quality of the opposite sex's erotic response by concrete and literal analogy with their own—with most of the confusing, perplexing, disappointing and even physically dangerous consequences which one would anticipate.

For example, most of the female members of the student group could remember occasions upon which their "innocently" flirtatious behavior had led to some rather angry and aggressive ultimata on the part of aroused males whom they were dating. Most of the males in the sex crimes group could remember incidents in which they had felt rejected and unattractive because the women in their lives had not been as eagerly and urgently aroused as males commonly are.

2. Several, more or less fortuitous, personal and situational elements appeared to be of some aid to both groups. One of the female members of the student group, for example, was concerned with the emotional reactions of her foster children, and she received some help from three members of the sex crimes group who had themselves been foster children. Also, one of the female members of the student group was struggling to understand a former marriage which turned out to be remarkably similar to the former marriage of a member of the sex crimes group. The dependency relationships and the struggle for power, as well as the use of alcohol, were nearly identical in each of these marriages. Both individuals were able to sharpen existing partial insights and integrate them emotionally to some degree.

3. Both groups proceeded with surprising speed and lack of defensiveness to the discussion of topics of deep emotional concern. The fact that the exchanges were known to be time-limited from the start may have been a factor in this, but the statements and reactions of the patients made it clear that the anonymity was also a very important factor.

4. Surprisingly strong emotional attachments and reactions occurred between members of the two groups. In fact, the intensity of these reac-

tions was clearly greater between the two groups than between members of the same group. This was more true of the student group than it was of the sex crimes group, which had pre-existed the tape exchange. Again, it was felt that the anonymity encouraged a freedom of expression which would have been difficult to obtain without it.

5. Emotional reactions between members of the sex crimes group during their regular group therapy meetings were markedly catalyzed by the tape-exchange sessions. The regular group therapy meeting directly following the first tape-exchange session was the stormiest session this group had ever had. Shortly after the introduction of the exchange sessions, the sex crimes group began discussing their masturbatory practices while imprisoned—a topic which we at the Sex Crimes Facility consider very important to work through but one which had effectively been skirted by this group in the past. It was more difficult to make similar observations of interactions between members of the student group since they met only in the tape-exchange sessions.

6. One member of the sex crimes therapy group was also undergoing family therapy sessions in which he and his wife were seen jointly. This patient began using, in the sessions with his wife, many of the ideas and insights gained during the tape-exchange sessions. At about the same time the tape sessions were introduced, this patient's joint sessions with his wife took a dramatic turn for the better.

DISCUSSION

The initial goal of the tape-exchange sessions was to facilitate emotional understanding of certain sociosexual realities. It was felt that this goal was achieved and that certain other unexpected therapeutic bonuses also accrued. Originally, the anonymity observed in the tape exchanges was considered a necessary concession to security and tradition. Apparently, however, it worked to hasten and heighten the intensity and cohesiveness in the inter- (and to a more limited degree also the intra-) group experience. It is probable that, not only the anonymity, but also the opportunity to avoid face-to-face encounter operated in much the same way as does use of the couch in individual psychotherapeutic contacts. In other settings, it may prove possible to use the tape-exchange approach as a device to accelerate intense group involvement and then allow the

group the option of discarding the protection of anonymity when the members begin to feel no further need for it.

Originally, the necessity to take notes and to delay reaction to taped communications was regarded as a disadvantage. However, particularly in the sex crimes population for whom impulsivity was often a problem, the requirement to delay response may actually have served a useful purpose.

A traditional preference for face-to-face confrontation and immediate, "natural" emotional participation may retard acceptance of this technique by therapists, but it is hoped that the positive results of this limited trial will encourage experimentation with different groups in varied settings.

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Brief Communications

PARTICIPANTS' REACTIONS TO TREATMENT IN A MARRIED COUPLES' GROUP

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This paper presents some evaluations made by married couples with respect to their experience as participants in group psychotherapy. The evaluations deal with the nature and effect of this experience on the marriage relationship.

POPULATION

The couples studied were members of four separate open-ended groups conducted by the authors within their private practices during a five-year period. Two of the groups were shared by the authors as co-therapists. The groups met weekly for one and one-half hour sessions. The maximum size of each group at any one time was four couples. The basic criteria for selection of the couples were the presence of a mutually defined marital problem and the willingness of both partners to participate.

The age range was between 19 and 56, with the majority in the 30 to 40 year group. All but one of the couples had children. College graduates

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dominated the population. Income was largely in the upper-middle range. The average length of treatment was six months (range: one month to two and one-half years).

METHOD

Each individual was sent a questionnaire[1] containing both multiple choice and essay questions. Thirty-four questionnaires were sent, and thirty responses were received from fifteen couples. Three professional colleagues[2] were enlisted to judge five of the essay questions. Each judge evaluated the same five questions independently.

FINDINGS

1. Participants were asked to rate the effect of the couples' group on their marriage according to a scale: not sure, little or none, moderate, great. They judged the degree of effect as experienced both at the time of termination and at the time of responding to the questionnaire. The answers are shown in Table 1.

TABLE 1

Degree of Effect of Group Experience on Marriage

Degree of Effect	At Termination		Currently	
	Men	Women	Men	Women
Great amount	9	5	2	2
Moderate	8	4	12	6
Little or none	1	2	1	4
Not sure or no answer	3	4	0	3

2. We tried to assess the nature of the effect on the marriage by asking: If the group experience has had an effect on your marriage, has that effect been very beneficial, moderately beneficial, slightly beneficial, slightly harmful, moderately harmful, very harmful? What is your answer currently and what would it have been at the time of termination? The results are shown in Table 2.

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[1] Devised by Mrs. Jacqueline Husek, M.A.
[2] Martin Berkowitz, Ph.D.; Charles Hurt, M.S.W.; Hindy Nobler, M.S.W.

TABLE 2

Nature of Effect of Group Experience on Marriage

Nature of Effect	At Termination		Currently	
	Men	Women	Men	Women
Very beneficial	3	3	2	1
Moderately beneficial	7	3	10	7
Slightly beneficial	2	3	1	2
Slightly harmful	1	2	0	1
Moderately harmful	0	1	1	1
Very harmful	0	1	1	1
No answer	2	2	0	2

3. The next multiple choice question asked was: Who in your opinion has benefited more from the couples' group (you, your spouse, your children, all about equally, none)? The answers agreed notably as between husband and wife; viz., when one spouse responded that he or she had individually benefited more, the answer of the other spouse confirmed that this was so; or if the husband believed that all of the family members had benefited about equally, the wife too responded in this vein. The majority of respondents (13) chose the "all about equally" category.

4. The judges rated as "helpful," "harmful," "neither," this essay question: Describe the change, if any, in your marriage resulting from your experience in the married couples' group. The answers led the judges to code the experience as "helpful" in 23 of the 30 responses rated.

5. The judges also rated answers to two questions regarding "changes in yourself as a marriage partner which you attribute directly to your experience in the group" and "changes in your spouse as a marriage partner which you attribute directly to the group experience." Judges were asked to rate the responses to these questions as "improved" or "no change." The ratings were: "improved" in 23 of 30 cases relating to changes in self, and "improved" in 21 of 30 cases relating to changes in the spouse.

6. Finally, the judges evaluated the degree of change in the relationship by analyzing responses to the following questions: (1) How would you describe or characterize your marriage before entering the couples' group? (2) How would you describe or characterize your marital relationship as it stands today? From the responses, the judges determined the degrees of difference as being: "little or none," "moderate amount," "great amount." Here, the population was rated in two thirds of the cases

as showing "moderate" or "great" change (one third each), with the remaining one third rated as showing "little or no" change.

The value of including essay questions in addition to multiple choice questions is brought out by this fact: the essay responses revealed that the treatment experience was actually of greater positive value than was indicated in the responses to the multiple choice questions. For example, one husband who had rated the effect of the group as "moderately beneficial" stated in response to the question regarding major changes in the marriage: "Major effect has been to establish a valid communication between us. . . . My self-confidence in facing the problems in the marriage situation has increased as a result of increased ability to recognize certain attitudes in myself and my wife at the times these attitudes manifest themselves, not later, and to communicate about these attitudes before they settle behind my defenses and curdle into hostility." In her response, a wife who checked "slightly beneficial" stated: "I seem to feel much less resentment toward my husband. This is probably due to my being able to express my anger more freely. At least, he knows what I'm thinking."

As a whole, the essay responses to the question on the major change resulting from the group experience stressed improved communication; this was mentioned directly in 17 responses. Reduction of fights and irritable exchanges between partners, improved sexual relationships, and improved relationships with the children were cited by a large number of respondents (20).

Responses to the questions about changes in self and spouse brought forth comments as to improvement in communication, self-perception, understanding, confidence, and consideration. Illustrative quotes: "I've really opened up." "I can better spot my own insincerities." "My anxiety attacks are reduced." "He's grown closer, more affectionate and honest." "She's treating me with greater respect."

6. One question asked for a description of the marital relationship before and after treatment. The answers indicated that typically there was a diminution of problems. This is shown by the following quotation: "Before treatment the marriage was shaky, subject to breaking up, more apt to explosion, less patience with the everyday problems. . . . Today, we don't seem to go to the brink of breaking up, less antagonism; some of the togetherness we had while attending the group, however, has worn off."

7. Finally, the respondents were asked to state *how* the group had influenced the changes within the relationship. The most frequently mentioned factor was the functioning of the group as *an open forum for communication*, encouraging direct and honest statement of feelings. This was referred to frequently (25 cases): "The experience of listening to and observing the other couples had a very strong effect upon me and my attitudes toward marriage and relationships in general. I found myself really thinking about what marriage was, what I wanted from it and what I had to bring to it in order to accomplish my part. . . . I had to listen to myself and I found I didn't always sound as right as I wanted to believe I was."

SUMMARY AND CONCLUSIONS

A questionnaire regarding the nature and effect of their experiences in a married couples' group was sent to seventeen couples. Fifteen, or a total of thirty individuals, responded. The length of their treatment had ranged from at least one month to two and one-half years. The preponderance of replies to both multiple choice and essay questions led to the conclusion that the major effect of treatment, in this population, was improved communication between marital partners. This improvement appears to have been brought about in the following way: (1) The use of male and female co-therapists provided a model for the group members. (2) The group facilitated confrontation and exploration of each couple by the other participants. (3) The experience of verbalization with the other group members encouraged increased verbalization between the marital partners, reducing acting out and diminishing neurotic exchanges.

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GROUP PSYCHOTHERAPY SCREENING SCALE: A VALIDATION STUDY

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I<small>N AN EARLIER PUBLICATION</small>, Salzberg and Heckel (1963) described a group screening technique for the selection of suitable candidates for group psychotherapy. Use of this method in a V.A. hospital eliminated the large backlog of new admissions who had not been seen, avoided some unnecessary diagnostic testing, made it possible for information to be communicated promptly to other staff members, and enabled psychotherapy candidates to initiate treatment in less than a week following admission to the hospital. A scale was developed from this screening technique. In a subsequent article, Salzberg and Bidus (1966) presented the scale and some initial attempts at validation. Rater reliability was found to be quite high (.86), and a factor analysis yielded four factors which were labeled as intellectual achievement, premorbid adjustment, attitude toward psychotherapy, and attribution of responsibility. A statistical analysis of the screening scale scores on all new admissions to a psychiatric unit of the hospital for a period of one year with a five-month follow-up revealed that the scale was highly useful in selecting patients for psychotherapy and to a lesser extent in predicting their ability to stay out of the hospital following discharge.

In the present study, all first admissions to one psychiatric unit of the same V.A. hospital were screened and rated on the scale for a period of three years. The ratings were made prior to selection for group psychotherapy. Records of movement in and out of the hospital were kept for

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these patients throughout the three-year period as well as for one year after the last patient had been screened.

Of the 977 patients who were screened, 407 participated in group psychotherapy and 570 did not. An analysis of variance indicated that patients in psychotherapy had significantly higher screening scale scores ($F = 329$, $P < .001$). This finding, of course, was influenced partly by the fact that the screening scale score was one criteria used for selection of group psychotherapy candidates. Successes (those who were discharged with maximum hospital benefits and were not readmitted) also had significantly higher screening scale scores than failures (all other categories), ($F = 13$, $P < .001$). In an attempt to ascertain the separate effects of the screening scale score and participation in group psychotherapy on success, four subgroups were compared. Of 316 patients who both scored above the mean on the screening scale and had participated in group psychotherapy, 195, or 61.7%, were successes. In contrast, of 386 patients who scored below the mean and did not participate in group psychotherapy, 175, or 45.3%, were successes. Of 91 patients below the mean but in group psychotherapy, and 184 patients above the mean but who did not participate in group psychotherapy, the corresponding percentages of successes were 50.5 and 56.0. A large proportion of the failures were composed of patients who were discharged from the hospital, were readmitted once, and then were discharged with no further readmission. This could be considered a partial success. Of the group psychotherapy failures, 44 per cent fell into this category, in comparison to 30 per cent of those failures who did not take part in group psychotherapy. Nineteen per cent of the group psychotherapy failures as compared to 30 per cent of the failures who did not have group psychotherapy remained in the hospital at the conclusion of the study. This seemed to be an additional indication that psychotherapy had some positive effect on prognosis, although, in this instance, screening scale scores may also have been a factor. The screening scale also differentiated among the failures. At the conclusion of the study, only 13 per cent of all screened patients were still residing in the hospital. Nine per cent of these had scored below the mean and only four per cent above the mean on the screening scale.

These results support the findings of the original study and indicate that the combination of a high screening scale score and participation in group psychotherapy appeared to affect prognosis more favorably than

either factor alone. Successes were also proportionately greater for patients who had only a high screening scale score or only group psychotherapy than for patients who had neither.

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A TECHNIQUE TO INTEGRATE THE SOCIAL ISOLATE IN A GROUP ACTIVITY

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GROUP ACTIVITIES FOR PATIENTS briefly hospitalized in a psychiatric unit of a general hospital have more value when the roles of the various group members are quickly identified and appropriately manipulated by the activity director. The natural leader of a group is usually readily recognized, but the isolate in the group who lacks friendly peer relationships and who may suffer much group hostility emerges more slowly. The following describes a simple and successful technique used to locate and manipulate both the leader and the isolate in a group of teen-aged psychiatric patients.

A group is viewed by Shibutani (1964) as "any collection of persons who are capable of consistent, coordinated action, action which is consciously or unconsciously directed toward some common objective, the achievement of which will bring gratification of some kind to all participants." From this definition, it appears that the group isolate is no more than a marginal member, and until he is accepted and feels accepted by the group, he will not find such gratification. A procedure was needed which would help the isolate to find rapid group acceptance, and for this, certain assumptions were made:

1. The social functions of groups formed in a psychiatric unit have the same basic purposes of those of any groups formed in a social milieu (Monroe, 1955).

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2. The role expectations of a patient are more clearly defined because of the structured social setting of a psychiatric unit and the rules of patient behavior, in comparison with other social situations.

3. Since role expectations are better defined, it is easy for patients in a group to identify with one another.

4. Within the group, leaders, followers, and isolates emerge. Obviously, many individuals have either been cast or have cast themselves in these roles before entering the psychiatric unit (Goffman, 1961).

5. It is good for the individual to have the support of the group. As Harry Stack Sullivan said, "Anxiety is aroused when there is danger of losing the support of other people." The patient, removed from his usual groups by hospitalization, must seek support from his therapist and fellow patients and adjust his self-concept in relation to them.

STUDY DESIGN

Thirteen patients, seven boys and six girls between the ages of 10 and 20, were studied. Group participation had already begun on a voluntary basis. Diagnosis, which varied from situational adjustment problems to schizophrenic reactions, was not a factor in forming the group. Activities were geared to the norms of teen-agers, and the therapist usually acted as a participant-observer. The Teen Group held meetings to plan and discuss their recreational activities and often there were group games or sport activities following the meetings.

All members of the group were in-patients at the Creighton Memorial Saint Joseph's Hospital, which is affiliated with the Creighton University School of Medicine. It is a general hospital with 120 beds in the psychiatric unit, and most of the psychiatric patients are hospitalized less than thirty days.

The first and easiest method tried of identifying roles in the group proved successful. A simple sociogram was completed, designed according to Caplow's (1964) principles, to measure degrees of "valence" between subjects. Valence is described by Caplow as "a variable used to measure the desire of members of an interacting pair to interact with each other." It is roughly synonymous with mutual attractiveness or interpersonal affect. Positive and negative valences were scored. A first-choice friend scored 3, a second-choice friend scored 2, and a third-choice friend scored

1. A first-choice least-wanted as friend scored a negative 3, a second-choice least-wanted as friend scored a negative 2, and a third-choice least-wanted as friend scored a negative 1. Leaders and isolates were simply determined on the basis of total points, both negative and positive, and by the number of choices received. The subjects were given brief questionnaires which they quickly checked and returned and were not informed of the results of the sociogram. Incidental information from the data was the identification of cliques within the group, and the sociogram also helped determine which pairs of patients could be expected to work well together.

After identifying the leader through the use of the sociogram, he was deliberately manipulated as a means to integrate the isolate into the group. The following procedure was used.

1. A formal meeting was held between the leader and the participating therapist.

2. Scores on the sociograms were revealed to the leader to give him proof of his leadership.

3. The isolate was also identified to the leader, and his aid was requested in bringing the isolate into the group.

4. The leader was asked to keep this information, as well as the therapist's goals, confidential.

ANALYSIS OF RESULTS

The sociogram, in the group discussed, revealed three leaders: Don, Agnes, and Janet. Of the three, Don received the highest composite score. The sociogram also revealed three isolates: Phil, Margie, and Nina. Phil and Nina were very new and not really known to the group, so it was felt that Margie would benefit most from deliberate integration into the group. Margie, six feet tall at age 13 and having a rather unpleasant physical appearance, was afflicted with Marfan's syndrome. Her self-esteem seemed particular low at the time of the study. Her diagnosis, in addition to Marfan's syndrome, was anxiety reaction in a schizoid personality. She was shy, cried easily, was anxious in any setting, and evidently reacted to social stress by attempting to withdraw from the situation.

Don, the leader, was diagnosed as schizophrenic with some sociopathic tendencies. He displayed grandiose ideation, often rejected authority, and manifested inappropriate hostility. Both Don and Margie came

from broken homes and had many ambivalent feelings about their parents and authority figures.

When Don was privately told that he had been identified as leader of the group, his response was frank and immediate, "Well, I'll be damned! This is the first time I've been a winner." Informed that Margie was an isolate in the group, he replied, "Well, that's understandable. It's because she's physically repulsive." The therapist discussed with Don his feelings about Margie and indicated that he, as leader, could help the group accept Margie. Flattered, and despite his previous comment, Don readily agreed to this.

The following day, the Teen Group met and the members were sitting and listening to rock and roll music. The therapist, fearing that an inactive period would allow the isolates to withdraw more, suggested that they go to a gymnasium area. Don, supporting the therapist, said, "Come on, let's go." The group, including Margie, did go, but she remained a marginal member of the group and soon quietly left. Letty, a girl who had accepted her to some extent, asked, "Where's Margie?" The therapist used this as a cue to point out that Margie had not joined the group activity but might have been encouraged to do so. Don, perhaps impressed by knowing his role as leader, was not his usual loud, boisterous self this day. He was quiet, very polite and accommodating. The group remained as quiet as their leader, yet seemed to enjoy the activity.

At the next Teen Group meeting when Margie arrived, Don directly involved himself by acknowledging her presence with, "Hi, Margie." The group followed his leadership. Pete's suggestion of group discussion was accepted, and soon there was a great deal of interaction among Margie, Pete, and Don. Margie, when encouraged by Don, was able to talk about her fears of being unable to make friends in a foster home. Another group member told Margie, "We like you, and if you can make friends here, you can make them away from here." The therapist felt that Margie was fully accepted into the group at this session. A sociogram retest a week later confirmed it.

DISCUSSION

This simple sociogram technique permits identification of the leaders and isolates in a group, gives definite goal orientation to the therapist,

and provides an adequate test of process by retest, using the sociogram. When hospitalization is apt to be of short duration, it allows for more immediate goal pursuit in group management. It is the conclusion of the therapist, involved as participant-observer in this study, that the goal of integration of the isolate was achieved, and the behavior and self-esteem of both leader and isolate were very favorably improved.

EPILOGUE

Both Don and Margie were under the care of the same psychiatrist. He noted, independently, an improvement in the dispositions of both coinciding with this period. Margie's attitude and manner continued to improve markedly in the three weeks that followed. Then she went to a foster home, and despite her previous doubts, made a good adjustment both to school and the family, becoming quite involved in their activities. According to his psychiatrist, Don gained new insight from his role as leader, is employed, and for the first time in his working history, has been faithfully punching a time clock.

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THE ROLE OF THE OBSERVER IN GROUP PSYCHOTHERAPY

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OBSERVERS HAVE BEEN associated with therapeutic and training groups in a variety of roles: as students and prospective leaders of groups (Krasner et al., 1964; Levin and Kanter, 1964), as collaborators (Rodrigue, 1959), as research assistants (Powdermaker and Frank, 1953), and as recorders (Chebabi and Pacheco, 1959). Frequently, an observer is expected to perform several of these functions simultaneously, often enough without their being explicitly delineated, thus leading to considerable difficulty after the first stages in the group process (Limentani et al., 1960).

This paper is concerned with those groups, therapeutic or training, conducted along psychoanalytic principles in which the leader actively interprets and the observer remains silent and records the verbal and nonverbal aspects of the interactions. Since observers have been used primarily because they contribute an objective appraisal of the situation, it seems imperative to consider how much objectivity this role allows, under what conditions, and which of the observer's functions are the most productive.

The passivity imposed on the observer by his silence and by his refraining from any type of activity during the group session except taking notes places the observer in a special situation akin to those in which deliberate abandonment of purposive ways of thinking gives way to regression and less consciously controlled processes. As in the case of the psychoanalytic patient during free association, the observer's rein on his own cognitive processes is relaxed, and in a state of free-floating attention

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he tends to become more attuned to preconscious or unconscious communication. The same factors predisposing to regression lead to a vastly increased receptivity toward emotionally laden communication. Evidence of this has frequently been mentioned in the literature as the "propensity" of the observer to become overly involved, highly excited, or downright disturbed by the group's exchange (Cerqueira, 1960; Chebabi and Pacheco, 1959; Levin and Kanter, 1964; Limentani et al. 1960; Powdermaker and Frank, 1953). These instances can be explained by the very nature of the observer's position as the passive-receptive partner in the therapeutic couple, the one who has no recourse to action or discharge. It is to be inferred from this that unless the observer can exercise great control, it is difficult for him to be "objective." Several authors corroborate this assumption (Chebabi and Pacheco, 1959; Krasner et al., 1964; Limentani et al., 1960; Powdermaker and Frank, 1953). Yet, we find that, most often, the observer's objectivity is put forth as a prominent reason why observers are used in groups.

As we see his most useful function, the observer cannot simply passively perceive, register, and respond subjectively to the stimulation he receives. His attentiveness to what he perceives has to be discriminating, and the data gathered have to be processed simultaneously with his objective observations of the group's behavior and interaction. Essentially, the observer does not need to resort to the kind of syntheses and other high-order cognitive functions that the leader must engage in in order to interpret. Thus, he need not move away from the group to the extent that the leader does and is thus more often bombarded by affect-charged unconscious communications. This oscillation between a state of free-floating attention with higher receptivity to primary process operations and that of perceiving correctly, discriminating, and integrating the stimuli received requires skills that can be learned, but only if they have previously been defined.

Far from being a handicap, the observer's particular position, if clearly understood, can be of great value to the leader-therapist. Precisely because of his increased vulnerability and maximum receptivity to unconscious messages, the observer can fulfill a complementary role in the therapeutic partnership, identifying conflicts and reactions not clearly verbalized or acted upon in the group session.

This function places a strain on the observer, but it becomes even more of a burden if the observer initially has no idea of what he will experience. Krasner et al. (1964) emphasize the need for structure and a clear delineation of the observer's role to allay the problems of over- and counter-identification with the patients and to decrease friction with the therapist. Limentani et al. (1960) note that the observer is "flooded with feelings" the expression of which he must postpone until he meets the leader. They add: "expressing these reactions to the leader is the essence of his function." When the observer and the leader meet to review the session together, the observer has the chance to become "active" and report his observations. Together, leader and observer evaluate the session in the light of the additional material supplied by the observer in terms of his emotional responses, wishes that became prominent, and fantasies that came to his mind at particular times during the session.

Some of his observations will be shared by the leader, but others may cause disagreement. Rather than putting aside those observations not concurred in by the therapist, and before considering them as caused by personal rivalry, differences of status, temperament or technique, the therapist should examine them thoroughly since they may offer a substantial clue to parallel conflicts in the group. For instance, the observer may be critical of the leader for not having been more active during the session. This wish of the observer's may also be what the group felt during the session but could not verbalize explicitly. The observer is unwittingly, the "carrier" of such a wish. In turn, the reaction of the leader toward the observer's comments can reflect his countertransference toward the group in reference to that particular wish. In essence, the therapist feels toward the observer as he unconsciously felt toward the group.

Once a conflict has developed between observer and leader, it is the responsibility of both to analyze it in terms of the group situation. Such a conflict is usually closely connected with those problems of transference and countertransference that have not been picked up, elucidated, and worked through in the group session. The therapist-observer relationship reproduces dormant or unverbalized conflicts in the group, and their analysis and clarification in the therapeutic relationship not only leads to a better understanding of the group dynamics operative at the moment but helps in their resolution. It is self-evident that if therapist and observer cannot settle their conflict, understand it, and work it through,

the therapist will miss or avoid the conflict in the group. Also, if the problem goes unresolved, the group perceives the friction between therapist and observer and utilizes it to increase their resistance.

Strong agreements and enthusiastic identification between the two partners can at times be just as representative of unspoken and unclarified problems within the group. In such an instance, it may be that the observer has strongly identified with the therapist and his countertransference, sharing the same blind spots and allying himself with the unconscious defenses of the therapist and reinforcing them. Both therapist and observer should learn to differentiate between agreement based on a realistic understanding and correct assessment of the group interaction and the kind of defensive enthusiasm that often hides hostile feelings toward the group and an unconscious wish to "defeat" it.

Although there is a fairly abundant description in the literature of the problems developing between therapist and observer and what can be done to decrease them, there is little mention of their *source* in the group interaction. It is an empirical fact that competition or rivalry between the leader and observer is not an ever-present problem but one that only appears prominently when stimulated in the group by the members' unconscious strivings. The competition generated between two responsible professionals never reaches the intensity nor the irrationality that is characterized in the group, but whatever conflict is present ought to be first examined in the context of the group and only when this is found not to be operative should it be dealt with as an interpersonal problem requiring for its resolution the rationality and responsibility of both the therapist and observer.

It is possible to avoid the more common drawbacks in the leader-observer interaction by careful selection of the observer:

1. If not well versed in group psychotherapy, the observer should have enough competence, skill, and knowledge of dynamics so that he does not experience his status as so much lower than the therapist that it fosters envy or inhibition on his part.

2. He should have enough personal knowledge of himself to be able to question his reactions and to be capable of cooperation in a common pursuit.

3. He should not be so afraid of "letting himself go" that he is unable to withstand the emotional impact of the group without considerable

anxiety, nor so unstable that he cannot tolerate his passive-receptive role without his powers of control and observation being shattered.

4. What is expected of him should be made clear from the very beginning so that he is free to express and question his feelings with the leader, knowing the conflicts that may come up, why, and how they will be used.

5. He should have an orientation similar to that of the group leader. If the observer has different views regarding theory and technique and favors approaches divergent from those of the leader, confusion, rivalry and unproductive disagreement are likely to result.

Needless to say, these are the ideal specifications. Most observers are students who do not fulfill some or most of these requirements. If the leader and observer find themselves in a situation in which they are not able to work through their difficulties, supervision of the couple, either by a supervisor aware of the implications of these problems or by means of a control group, usually establishes the desired objectivity.

As a rule, therapist and observer should meet after each session when the material is fresh in order to discuss the data and their feelings. They can then meet again before the next group session to discuss their findings in the presence of a detached moderator (supervisor or control group) to decrease the possibility of these problems going unresolved.

If the observer's function is viewed in the manner proposed here, the observer is not relegated to a secondary position but is instead given a chance to contribute actively. This approach encourages the use of the observer for the elucidation and resolution of transference and counter-transference problems since such conflicts are reproduced within the leader-observer relationship.

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Book Reviews

Edited by

I R V I N G   A .   G O L D B E R G ,   Ph.D.

ON HUMAN SYMBIOSIS AND THE VICISSITUDES OF INDIVIDU-
ATION, VOL. I. By *Margaret S. Mahler*. New York: International
Universities Press, 1968, 271 pp., $7.00.

This book is the first part of a summation of more than thirty years
of work and a reworking of over twenty papers focusing particularly on
autistic and symbiotic childhood psychoses. This volume concentrates on
understanding childhood psychoses, while the subsequent one will deal
with normal dedifferentiation during the first three years of development.

The newborn in the first month of life is in an autistic hallucinatory
state in which he cannot distinguish his own few tension-reducing at-
tempts from need-ministrations by his mother. Dawning awareness of the
mother as a need-satisfying object launches normal symbiosis, and the
infant then behaves as though he and his mother were an omnipotent
system—a dual unity with a common boundary. The mother's counter-
part contribution is her "holding behavior," or "primary maternal pre-
occupation," which serves as an auxilliary ego for the infant. "Hatching"
from the autistic state occurs thanks to the outward-directed perceptual
activity of the infant. From the ninth month on, the maturational spur
of active locomotion leads the infant to separate in space from the
mother. From the selective responses of mother and child to each other's
cues, the child begins to emerge as an individual. The child's practicing
at separating himself physically from the mother peaks in the middle
of the second year. As the infant becomes more aware of his separateness
from his mother, he no longer takes her presence for granted and actively
keeps returning to share every new experience with her. Strong at this
phase is the fear of re-engulfment by the mother. This fear dissipates by
the fourth year when individuation has been established.

The mothering partner must provide the most primitive orientation, so defenseless and unoriented is the infant as to what is inside and what is outside the self. In autism, early organismic distress destroys the perception of the mother as functioning on the infant's behalf, so that the mother is not perceived as a representative of the outside world. The symbiotic psychotic child has some awareness of the mothering principle but alternates between wanting to fuse with the "good" part object and wanting to ward off re-engulfment by the "all-bad" part object.

The intermixing and interchangeability of both types of psychosis are examined, since some children are primarily autistic while others, seemingly, have regressed to that state from a symbiotic psychosis because of stress. In studying mother-child interaction, "communicative mismatching" (a useful concept for group therapists in thinking of the fit between members of the group and therapist) is detailed. Mothers were found to be adept in observing and explaining the child's mystifying behavior, but often they could not show appropriate responses because they could not bear the child's intense demands for symbiosis. These mothers did not necessarily show a need for "parasitic symbiosis." Such factors, however, supported a static state of psychosis in the child.

Different strategies of treatment are required depending on the type of regression. The autistic child must be lured into quasi accidental, tangential contacts with humans to reduce panic. Children with symbiotic psychosis must be protected from panic due to separateness. In either instance, one seeks to provide a corrective symbiotic experience. It is recommended that the therapist enlist the mother directly to work together with the child. In this way the mother can provide clues for understanding the child and can identify with the therapist so that she will feel capable of dealing with the child at home.

Group therapists working with the parents of such children will be interested in seeing the part the parents play in supporting the static state of psychosis and in helping to relieve it, as well as the extent of the impact of such a child on the parent. Of more general interest to the group therapist is the chain of development from autism through symbiosis to separation-individuation, since this has its counterpart in the early life of all groups. In the beginning members rely on certain fantasies to make the pain of being in the group more bearable; this is reminiscent of the normal phase of hallucinatory autism. The grand feeling of being together in a group, so common later on, is reminiscent of the symbiotic phase. Only as people stand out as individuals do they begin to

do useful work in the group; this reminds one of the emergence of the human as an individual in the phase of individuation-separation.

It is interesting that in this specialized corner of therapy, a small group consisting of therapist, mother, and child is a *sine qua non* for success, while at the same time peer groups for these disturbed children are noxious. The clinical examples are invaluable for clarifying the theory.

<div align="right">

MAX DAY, M.D.
Newton Centre, Massachusetts

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JOY: EXPANDING HUMAN AWARENESS. By *William C. Schutz.* New York: Grove Press, 1967, 223 pp., $5.50.

This is a book about group therapy in its most avant-garde form. A series of action-encounter exercises are presented which are claimed to provide joyous release and liberation. The question is whether this methodology can be utilized in the service of working through unconscious conflict, or is it, rather, a seductive way of acting out deep-rooted anxieties with transitory joyful experiences? Can these prescribed activities be integrated into a reconstructive-reintegrative plan, or do they do no more than provide excitation value for lonely, inhibited participants?

In this reviewer's opinion, what Schutz outlines is a significant contribution or a potential danger depending on who is directing the therapy. The highly sensitive, analytically oriented group therapist can selectively utilize some, or even all, of these action exercises in a well-thought-out treatment plan for a particular patient; he can integrate some of the approaches into his own particular method and style of work. On the other hand, the therapist not tuned in to the subtleties of transference-resistance and the working-through process may foster charismatic illusions through indiscriminate use of these exercises. He may induce acting-out or playing-out behavior which temporarily alleviates or dissipates anxiety, only to have the anxiety intensify in the joy-extinguishing world outside the encounter group.

There is no question but that this book is a bold attack on the evasiveness and deceptiveness of the predominant methods of verbal treatment. Rightly, it opposes the often empty, affectless explorations through the analytical "why." It represents a pendulum that is swinging away from the forces of detachment and impersonality toward sensory re-awakening and the experiencing of authentic levels of existence.

While it tends to offer magical and illusory solutions, this should not be allowed to obscure the fact that it also contains solidly imaginative

action exercises which can be integrated into contemporary group therapy practice. The book merits the consideration of every group therapist who is eager to keep up with our rapidly changing times and who is committed to expediting and improving the therapeutic effectiveness of his work.

ZANVEL A. LIFF, Ph.D.
New York, N.Y.

FAMILIES OF THE SLUMS: AN EXPLORATION OF THEIR STRUCTURE AND TREATMENT. By *Salvador Minuchin, Braulio Montalvo, Bernard G. Guerney, Jr., Bernice L. Rosman,* and *Florence Schumer.* New York: Basic Books, 1967, 447 pp., $10.00.

We now acknowledge that psychotherapy has been a social class-bound business. The enterprise of psychotherapy, the techniques of psychotherapy, and the theories of human behavior derived from psychotherapy have reflected middle-class assumptions and biases. Not only has this misled the whole psychotherapeutic enterprise at times, it has also proved a stumbling-block when middle-class psychotherapy has been attempted with the impoverished and disenfranchised. These observations are accentuated when we turn to family therapy. Much of family therapy is built upon the sociology of middle-class family structure, and most of the family therapy work reported is "middle-class" family therapy theory and technique.

For this reason this is a very significant book that makes pioneering theoretical and clinical contributions to family therapy. The clinical and research data were gathered during the time that Dr. Minuchin was director, and the other authors senior staff members, of the Family Research Unit, Wiltwyck School for Boys in New York.

Clinical experience with children from the slums of New York impressed the authors with the uniform psychological characteristics of these children: (1) the diffuseness of experience; (2) the peaks of immediate reactivity and equally fast de-fusing of affect; (3) the inability to recapture and explore an event; (4) the predictable projective nature of responses. What family experiences produced these stereotyped responses to the world, robbing these children of their ability to experience the rich, subtle complexities of life? A clinical and research project was designed to study the nature of family interaction in impoverished, unstable families of the slums.

Excerpts from the transcriptions of the treatment of three families

are presented. The detailed analyses of the transcripts focus on a study of: (1) therapist behavior; (2) responses of family members to therapist interventions; (3) interactions between the therapists; (4) responses of family members to each other. The therapeutic interventions were aimed to challenge: (1) the communication system; (2) the structure of the family; (3) the affective system. This is no success story. Sometimes the therapists sound effective, sometimes woefully inept. But the authors were not out to prove themselves, but to learn from, as well as help, these families. The authors report their learning in a straightforward way that can teach us much. The therapists' role may seem strange to urbane sedate therapists; "At certain times the therapist must yell more vigorously than the family members; dramatize his affect by making his silence audible; change his seat to increase or decrease proximity; introduce examples from his personal life; or use audibly four-letter words that the family members use secretly among themselves. It is in the artistry of appropriate selection and timing in the use of such maneuvers of mood control that the therapists' messages achieve a palpable reality for family members" (p. 286).

Two major features characterize these families: parents' responses to children's behavior are relatively random and therefore deficient in the qualities that convey rules which can be internalized; and the parental emphasis is on the control and inhibition of behavior rather than on guidance. Parents and children become involved in a system of "enmeshment-disengagement" because the family cannot function as a structural unit as it exists. However, the authors are quick to point out that the families are by no means uniform, that there are a number of significantly different constellations. They propose the following typology: the disengaged family, the enmeshed family, the family with the peripheral male, the family with nonevolved parents, the family with juvenile parents. For each they suggest relatively specific therapeutic maneuvers.

The latter part of the book describes two research instruments developed to assess family interaction: the Wiltwyck Family Task and the Family Interaction Apperceptive Technique. Those involved in family research will want to study these instruments carefully. The authors present a cogent case for the inadequacy of data derived from individual interviews when one is faced with the characteristic family entanglements that make up the life space of each family member.

There is a wealth of information here on family dynamics, on the relationship of family function and structure to social dynamics, and on clinical techniques. This book should be most influential in community

mental health program thinking, as well as for the more general field of family therapy. Every group therapist will want to read and carefully study this superb study.

E. MANSELL PATTISON, M.D.
Seattle, Washington

PSYCHIATRY IN THE AMERICAN COMMUNITY. By *H. G. Whittington.* New York: International Universities Press, 1966, 476 pp. $10.00.

The last few years have witnessed significant changes in attitude toward community psychiatry in this country. What was once heralded as a program of salvation for the "mentally ill" has now lost some of its promise and lustre and is coming more into realistic perspective. The hybrid organizational structure of the community mental health center with its local governing boards, private and public subsidies, and umbrella of federal control presents a melange of social, economic, and professional difficulties. Dr. Whittington's book offers a survey of these problems and useful ideas about coping with the frequent and often crippling frustrations which confront professional persons working within these parameters.

There are twenty-nine chapters in the book, each of which may be read as an individual paper. An attempt to provide comprehensive treatment of a subject as broad, rapidly changing, multifaceted, controversial, and ill-defined as community mental health must necessarily fail to some extent, but if the author's purpose was to provide a survey of the subject, then his objective has been realized. The multiple issues raised in this text simply could not be considered in depth in a single volume, but more definitive positions could have been taken on critical issues by one who assumes the authority implied in writing a book. The author is so successful in his attempt not to be "dogmatic" that the effort to be "stimulating and provocative" is often lost in a morass of equivocation. The book lacks integration and a conceptual framework, each of which would have enhanced its readability and usefulness. The references are adequate but not comprehensive; there is no index. In spite of its defects, however, this volume may be of assistance to the uninitiated professional entering the arena of community psychiatry—and arena it is.

DANIEL V. VOISS, M.D.
Portland, Oregon

DEPRESSION: CLINICAL, EXPERIMENTAL AND THEORETI-
CAL ASPECTS. By *Aaron T. Beck*. New York: Hoeber Medical Divi-
sion, Harper & Row, 1967, 400 pp., $10.50.

The mere fact of belonging to, being recognized by, and being ac-
cepted in a group is often considered therapeutic in itself. Group therapy
has been called an antidepressive medium. But a common criticism of
group therapy is that it obscures depression through its stimulant-excita-
tion value rather than working through the deeper sources of depression.

Even though no reference is made to groups or group therapy, the
validity of these simplistic comments may be challenged by a thorough
reading of this definitive book. This volume without doubt transcends all
previous writings on depression. With depression as a syndrome on the
increase, every therapist should become as knowledgeable as possible
about its origins, dynamics, and treatment. This book offers an up-to-
date, sophisticated, and high-level opportunity to become so.

Not only does Beck share the findings of fifteen years of personal
research, he also offers a comprehensive and well-organized presentation
of every aspect of the causes and possible cures of depression. This book
is divided into five major parts which cover both the clinical and theo-
retical literature in areas such as biology, biochemistry, psychoanalysis,
and psychodynamics. The last section discusses treatment approaches,
including the use of drugs, E.C.T., and psychotherapy.

The most interesting chapter for this reviewer was one on cognition
and psychopathology in which Beck indicates how differential diagnosis
may be sharpened by using the cognitive content. He writes that, "Cogni-
tive distortions lead to the affective and motivational symptoms that are
characteristic of depression. The misinterpretation of experience in terms
of deprivation leads to sadness just as in the case of actual deprivation.
Unrealistic negative expectations lead to hopelessness, just as do reality
based expectations. Similarly, the negative view of the world and of the
self and the future strips the patient of any positive desires and stimulates
the desire to avoid the apparent unpleasantness, intensifies dependency
wishes and evokes wishes to find an escape route via suicide."

An unusually extensive bibliography and the inclusion of the Beck
depression inventory together with instructions for administration and
scoring are added benefits to the reader. This book is must reading for all
group therapists.

ZANVEL A. LIFF, Ph.D.
New York, New York

Books Received

COUNSELOR PERCEPTIONS OF PROFESSIONAL DEVELOPMENT. By *Neil S. Dumas, Alfred J. Butler* and *George N. Wright.* Madison, Wisc.: University of Wisconsin Press, 1968 (price unlisted) 39 pp. (paperbound).

ON HUMAN SYMBIOSIS AND THE VICISSITUDES OF INDIVIDUATION. By *Margaret S. Mahler.* New York: International Universities Press, 1968 ($7.00) 271 pp.

THE WRITINGS OF ANNA FREUD, VOL. IV: INDICATIONS FOR CHILD ANALYSIS AND OTHER PAPERS. By *Anna Freud.* New York: International Universities Press, 1968 ($12.00) 689 pp.

RESEARCH MEDIA. By *Ann B. Trotter, George N. Wright,* and *Alfred J. Butler.* Madison, Wisc.: University of Wisconsin Press, 1968 (price unlisted) 53 pp. (paperbound).

SUICIDAL BEHAVIORS: DIAGNOSIS AND MANAGEMENT. Edited by *L. P. Resnik.* Boston: Little, Brown & Co., 1968 ($15.00) 536 pp.

LSD PSYCHOTHERAPY. By *W. V. Caldwell.* New York: Grove Press, 1968 ($7.50) 329 pp.

PSYCHOTHERAPY IN ACTION. By *D. Ewen Cameron.* New York: Grune & Stratton, 1968 ($8.50) 228 pp.

ECOLOGICAL PSYCHOLOGY. By *Roger G. Barker.* Stanford, Calif.: Stanford University Press, 1968 ($7.50) 242 pp.

WOMEN AFTER TREATMENT. By *Shirley Angrist, Mark Lefton, Simon Dinitz,* and *Benjamin Pasamanick.* New York: Appleton-Century-Crofts, 1968 (price unlisted) 333 pp.

THE GAY WORLD. By *Martin Hoffman.* New York: Basic Books, 1968 ($5.95) 212 pp.

AN INTERIM GUIDE TO THE CANNABIS (MARIJUANA) LITERATURE. By *Oriana Josseau Kalant.* Toronto, Canada: Addiction Research Foundation, 1968 (no charge) 39 pp. (paperbound).

EXPANDING CONCEPTS IN MENTAL RETARDATION. Edited by *George A. Jervis*. Springfield, Ill.: Charles C Thomas, 1968 ($12.50) 262 pp.

COMPREHENSIVE MENTAL HEALTH. By *Leigh M. Roberts, Norman S. Greenfield*, and *Milton H. Miller*. Madison, Wisc.: University of Wisconsin Press, 1968 ($10.00) 339 pp.

THE MENTAL HEALTH COUNSELOR IN THE COMMUNITY. By *David S. Shapiro, Leonard T. Maholick, Earl D. C. Brewer*, and *Richard N. Robertson*. Springfield, Ill.: Charles C Thomas, 1968 ($12.75) 207 pp.

NEW THINK. By *Edward de Bono*. New York: Basic Books, 1968 ($5.95) 156 pp.

THE PSYCHOANALYTIC STUDY OF THE CHILD, VOL. 23. Edited by *Ruth S. Eissler* et al. New York: International Universities Press, 1968 ($12.00) 512 pp.

WORK AND HUMAN BEHAVIOR. By *Walter S. Neff*. New York: Atherton Press, 1968 ($8.50) 280 pp.

A BRIEF HISTORY OF THE AMERICAN GROUP PSYCHOTHER-APY ASSOCIATION—The First Twenty-Five Years: 1943-1968 by E. Mansell Pattison, M.D. with the collaboration of the Committee on History, American Group Psychotherapy Association; Helen Durkin, Ph. D., Chairman.

This interesting pamphlet is available to A.G.P.A. members at no charge, and to nonmembers for one dollar. Please write the A.G.P.A. office, 1790 Broadway, Room 702, New York, N.Y. 10019 for your copy.

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MARTIN A. BEREZIN, M.D., and SIDNEY LEVIN, M.D., Editors

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AMERICAN JOURNAL OF PSYCHOTHERAPY

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MENTAL HEALTH IN-SERVICE TRAINING

BEULAH PARKER, M.D.

$4.00

Mental Health In-service Training offers a theoretical orientation and practical guidelines for members of the psychological professions, psychiatrists, analysts, clinical psychologists, and psychiatric social workers who hope to participate in community psychiatry by acting as mental health consultants to members of helping professions such as nurses and teachers. The book is based on personal observations and opinions of the author who served for ten years, between 1947-1958, as Psychiatric Consultant to the Berkeley, California Department of Public Health.

A program of in-service training developed by the author was among pioneer efforts to improve community mental and emotional health by increasing the psychological understanding of health department personnel and their effectiveness in helping clients deal constructively with ordinary problems of living as well as with the crisis situations which often precipitate emotional disturbance. Workers were given an opportunity to bring for discussion questions relating to situations encountered on their jobs, and the consultant used workers' own material in different ways to educate them about psychological mechanisms and various aspects of normal and abnormal behavior. The program is discussed and illustrated with descriptions of actual cases. Theoretical comments are also supported by many concrete examples from subjects raised in group sessions. Potential mental health consultants are alerted to characteristic attitudes found among members of three professional groups with whom they may be working, and are shown how a leader of in-service training may help workers keep such attitudes from impeding their professional task.

ABOUT THE AUTHOR

Dr. Parker is a psychoanalyst in private practice in Berkeley, California, faculty member at the Center for Training in Community Psychiatry, and Lecturer at the University of California School of Public Health where, for ten years, she conducted a graduate seminar on mental health. Formerly, in addition to consulting with the city health department, she worked on the university student health psychiatric service, and spent a year engaged in research on schizophrenia at Yale University. She is the author of *My Language Is Me,* an account of psychotherapy with an autistic adolescent.

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LECTURES IN MEDICAL PSYCHOLOGY

Introductory Lectures on the Care of Patients

GRETE L. BIBRING *and* RALPH J. KAHANA

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Repeatedly during the last two decades—and increasingly so since her retirement from the Faculty of Medicine of Harvard University—the colleagues and former students of Grete L. Bibring have asked her to put into permanent form the heart of the brilliantly instructive course she gave for much of that time to the students of the Harvard Medical School and to the physicians, psychiatrists, social workers, nurses, and dietitians of Beth Israel Hospital in Boston.

Now at last—with the active collaboration of Ralph J. Kahana, long her colleague and co-worker—Dr. Bibring has acceded to these many requests. The result is *Lectures in Medical Psychology*, a lucid and systematized presentation of those aspects of psychoanalytic psychology which Dr. Bibring considers essential for all those engaged in general medical and hospital care of the ill to absorb and practice.

In this new volume, Dr. Bibring and Dr. Kahana have taken what she viewed the indispensable portions of her lecture course and have reorganized, recombined, and reintegrated these within a unified, continuous framework.

The book sets forth the psychological development of the various personality types most commonly encountered among hospital patients. Extensive clinical material is used to illustrate the theoretical concepts, as the theoretical concepts in turn are used to provide a deeper understanding for the clinical material. Then, in a presentation of psychotherapeutic procedures applicable to the cases of differing types of medical patients, the lectures deal with characteristic problems: how to prescribe a diet; how to keep active patients in bed; how to prepare patients psychologically for impending surgery; when to disclose to a patient the nature of his illness (and how to disclose as well as how much to disclose, depending on the personality of the patient); and other problems in the medical management of illness. Throughout the volume, whether the formative childhood years are being discussed, or such other critical periods as those of puberty, pregnancy or old age, the emphasis is on the individual personality of the patient and how, at every step of his development, the medical and surgical care he receives must be related to his individual needs.

The purpose of the book—like the goal of Dr. Bibring's original lecture course—is to bring to medical and hospital management of the ill a broadened, deepened appreciation of psychological factors which, if properly understood, can do much to speed the recovery of patients and lighten the arduous tasks of the healing and helping professions.

ON HUMAN SYMBIOSIS
AND THE VICISSITUDES OF INDIVIDUATION

Volume I—Infantile Psychosis

MARGARET S. MAHLER, M.D.
In Collaboration with MANUEL FURER, M.D.

$7.00

Dr. Mahler's delineation of the syndromes of childhood psychosis and her extensive investigations of these phenomena are widely known. Her unique design for the therapy of severely disturbed preschool children is now widely used in many treatment centers in this country and abroad. This volume, based on an impressive body of clinical and theoretical knowledge, documents the evolution of her thinking.

As the author herself says: "This first volume of a two-volume book will be devoted to a detailed explication of my theory of human symbiosis and its most pathological vicissitudes. It is the result of historical circumstances that my concern with extreme disturbances of pathological symbiosis preceded my present study of 'The Normal Separation-Individuation Process.'"

Dr. Mahler was trained in Vienna, in pediatrics, psychiatry, and psychoanalysis. For many years she worked closely with W. Hoffer, A. Aichhorn, and Anna Freud. At that time she first began to observe childhood disturbances that had previously not been recognized and therefore were invariably misdiagnosed.

"Ever since the early 1930s, in clinical child psychoanalytic practice, I have been encountering rare cases of severe emotional disturbances in children, the clinical picture of which did not fit into the nosological category of neurosis; at the same time they could not be forced into the wastepaper basket category of organicity. But there has been a great resistance, emotionally tinged, against acknowledgment of the existence of schizophrenialike derangement in little children."

If this resistance has begun to yield somewhat, no little credit must be granted to the stringencies of Mahler's logic and the penetration of her insights in the course of evolving the theory of the symbiotic origin of infantile psychosis.

In a characteristic burst of candor, the author in her introduction muses on "why this first volume of a two-volume book *On Human Symbiosis* has taken so long to be written and has therefore been published later than I would have wanted it to be.

"I have been working and lecturing on this question for some twenty-five years, during which I have written more than a score of papers that have dealt, directly or indirectly, with the problem of childhood psychosis. . . . The simple collection of my papers would have had this advantage: that the reader would have availed himself, far more readily than he could have otherwise, of any of my papers as they were originally written. This venture, however, did not seem to be challenging enough. . . . I decided instead to write a book, that is to say, to use my papers on the subject only as a basis, a guideline, so to speak, for an elaboration of the symbiosis theory of the development of the human being, and in this first volume to deal with its most pathological vicissitudes."

Her decision was most fortunate, for the result is an important and original contribution—a milestone in the understanding and treatment of childhood psychosis.

THE PSYCHOANALYTIC STUDY OF THE CHILD

Edited by RUTH S. EISSLER, ANNA FREUD,
HEINZ HARTMANN, MARIANNE KRIS

Volume XXIII, $12.00

"Each year *The Psychoanalytic Study of the Child* is reviewed in various journals with justified accolades for its general content. Some reviews fulfill the concept of the responsibility of the reviewer by agreeing with some articles, disagreeing with others. This reviewer [Irene Josselyn], having all the volumes available with many articles underlined, and many marginal notes of agreement, associations, or protest, would find it too confining to review this volume, or any of the preceding volumes, by such detailed consideration of each article, or to discuss selectively some and ignore others. The primary value of *The Psychoanalytic Study of the Child* has its source in the critically selective activity of its Editorial Board. The articles are never poorly conceptualized, unsoundly developed, insignificant, or based upon a flight into fantasy. The reader may disagree with certain concepts presented, but to disagree validly he must set himself the task of a scholarly evaluation of that with which he disagrees and that which is his own counterformulation.

"There is a tendency among many who write for psychoanalytic publications to attempt to reconfirm what has already been accepted, or to utilize the accepted to justify a conclusion about an observed phenomenon. Perhaps child analysts find this circular reasoning or confirmation of the *status quo* more difficult to accept than do those involved primarily in adult work because so often the child in therapy confronts the therapist with currently developing, fluid ramifications of the nuclear conflict that seems to suggest broader aspects of psychosexual development than does the material that returns from childhood during the analysis of an adult. The increasing understanding gained through child analysis will inevitably enrich not only the practice and theory of psychoanalysis, but, equally, enlarge our general knowledge of human psychology.

"*The Psychoanalytic Study of the Child*, in the current volume as well as preceding ones, plays a significant role in bringing not only the child analysts, but equally analysts interested solely in the analysis of adults, concepts that would seem to be confirmed by, or confirmable through, child analysis. The articles selected are such that they, in some cases, concretize previously vaguely conceptualized ideas, but, more importantly, arouse in the reader questions that stimulate further thought. As many previous reviews have indicated, the annual appearance of *The Psychoanalytic Study of the Child* is always anticipated and never disappointing. Each volume, with its publication, becomes a 'must' on the reading list of those seeking stimulating reformulations and new concepts in the broad field of psychology; this volume is definitely no exception."
—*Journal of the American Academy of Child Psychiatry*

THE DREAM IN PSYCHOANALYSIS

LEON L. ALTMAN, M.D.

$7.50

In recent years, psychoanalysis has witnessed a tremendous upsurge of interest in ego psychology. At the same time there has been a diminution of emphasis upon the dream. As new formulations of adaptation, identity, and psychic energy have come to the fore, dream interpretation as a major clinical instrument has fallen into relative disuse.

In fact, writes Dr. Leon L. Altman in his Introduction to this book, "many of those recently trained in psychoanalysis do not know what to do with the dream. . . . Although students and recent graduates may understand dreams easily enough and can translate them from the language of the unconscious into their native tongue, they do not know how to integrate dreams with the problems the patient brings to psychoanalysis."

Convinced that, as he puts it, "psychoanalysis without embracing the dream is inexact and incomplete," Dr. Altman has written *The Dream in Psychoanalysis*. His aims are "to revive interest and enthusiasm for the dream [and] to reaffirm the extent as well as limitations of its importance in the practice of psychoanalysis."

Dr. Altman's intention, however, has *not* been to write a book on the meaning of dreams. Rather, what he has given us is a volume on *technique*—"an exposition of the clinical approach to making the latent content [of the dream] available and meaningful to both patient and analyst . . . an account of the clinical judgments which must be made and the steps taken to this end."

ABOUT THE AUTHOR: Leon L. Altman, M.D., is a member of the American Psychoanalytic Association, the New York Psychoanalytic Society, and the Psychoanalytic Association of New York. For more than fifteen years he has taught the course on dreams in the Division of Psychoanalytic Education of the Department of Psychiatry, Downstate Medical Center, State University of New York, where he holds the rank of Clinical Associate Professor of Psychiatry.

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MASSIVE PSYCHIC TRAUMA

Edited by HENRY KRYSTAL, M.D.

$10.00

Massive Psychic Trauma is a comprehensive presentation of clinical findings and theoretical formulations by psychoanalysts and psychiatrists who have had extensive experience with the treatment of survivors of the Nazi extermination camps and the atom bombings of Japan.

Citing numerous case histories and drawing heavily upon the records of actual treatment sessions, fourteen contributors document the stages of psychological shock, reaction and defense, as well as the personality changes which have come to be recognized as characteristic of the aptly named "survivor syndrome." They explore the similarities and differences between this tragically contemporary syndrome and those hitherto associated with psychic traumas such as serious illness, prolonged convalescence, natural disaster, the threat of sudden death, and the loss of a loved one.

Of particular interest are the sections that probe the implications of the "survivor syndrome" for those professional people who deal with its victims on matters of compensation, restitution, physical rehabilitation, and counseling.

The contents of *Massive Psychic Trauma* are drawn from the proceedings of a conference series on The Late Sequelae of Massive Psychic Trauma, held at Wayne State University. Dr. Henry Krystal, who was a principal organizer of and contributor to the series, has edited the volume, selecting the papers for inclusion, supplementing these with excerpts from the extensive discussions that took place, and providing, where needed, introductory and summary notes.

INTERNATIONAL
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Interaction and Insight in Group Psychotherapy: The Case for Insight

FERN J. AZIMA, D.Ps.

THERE IS LITTLE DOUBT that both insight and interaction are essential ingredients in any group psychotherapy. To identify my own position on this panel, I would say that I subscribe to the group analytic psychotherapy approach in which conflicts are gradually unfurled and worked through via insight in an interactional setting. In other words, somewhat the best of both worlds is achieved, for relevant traditional Freudian concepts are utilized without necessitating the loss of the concepts of group process, group interaction, and group tension. A controversial question during the last ten years has been which way group therapists should vector themselves: deeper or broader, vertically or horizontally? There has developed the mystique or misconception that the deeper the core of the personality penetrated, i.e., the earlier the pregenital object relations brought into consciousness, the better the group process. The counter mystique is the proposition that the more the present phenomenological field interactions are discovered, the better. This latter emphasis has opened up the transactional, existential, and family approaches; at certain points the search is not for the core but for adding on more and more relevant family members and/or more and more relevant nonverbal indices. The basic difference in approach, needless to say, is the relevance of transference interpretations. Many of the earlier

analytically oriented existentialists (Mullan and Sanguiliano, 1958; Whitaker and Malone, 1953) soon modified or dropped the transference or "T" search. Others, including Ezriel (1950), held fast, while still others, such as Foulkes (1965) and Foulkes and Anthony (1957) and Durkin (1964) modified their stress on the individual transference neurosis to include transference in present, conscious, here-and-now interactions as mediated by historical displacements. This, basically, is also my own point of view, and my technique is to utilize the concepts of transference and insight and working through insofar as they relate to the present, here-and-now situation of interaction. Certainly, neither extreme can work effectively in the group setting. Intellectual insight, shorn of emotional connotations, is a didactic understanding that leads to no change or alteration of the neurotic process. Interaction alone, the being-with-being, the acting for acting, the feeling-for-feeling, I am also convinced, brings about no true change.

To define insight in a generalized fashion, it is the process of "keen discernment or understanding, penetration; immediate apprehension or cognition" (Webster's, 5th Edition). In the psychiatric sense it means the ability for the patient (and the therapist) to see how present faulty behaviors are linked to unsolved conflicts. In the narrower psychoanalytic area, insight is usually (but not always) the end-result of countless hours of working-through of a problem from a multitude of points of view which enable the individual gradually to lift the distortions and to have a true certainty about the historical links of the origins.

Menninger (1958) says, "Insight is not just seeing that something in the analytic situation is similar to something in childhood, or seeing that something in childhood is reflected in the activities of his contemporary situation, or seeing that something in his contemporary situation is a reflection of something in the analytic situation. In the proper sense of the word and in the useful sense for psychoanalytic technique, it is the simultaneous identification of the characteristic behavior pattern in all three of these situations, together with an understanding of why they were and are used as they were and are."

Richfield (1954) has remarked that the voice of intelligence is not only soft but speaks with two voices; that is, there are two kinds of insight, based on the fact that there are two kinds of knowledge, two different ways in which we can know things, as illustrated by the way in

which we know alcohol and the way we know strychnine (Bertrand Russell). "What Reid and Finesinger (1952) have called 'dynamic insight,' the 'intellectual summum bonum of analysis,' actually may be achieved by the effective timing of both fundamental kinds of insight in an appropriate order governed by the peculiarities of each case."

Insight, according to Slavson (1966), needs to be understood not as intellectual comprehension but as the outcome of working through resistances and defenses and overcoming character rigidities. This alone makes it possible for the patient to view unhesitatingly the noxious components of his personality without suffering narcissistic injury; without this, emotional growth is virtually impossible. Intellectual understanding is not insight. It is the "working through" process that leads to insight and is the alchemic ingredient.

In summary, insight appears to be an ego capacity to modify resistances and defenses to allow the state of clear and satisfied understanding of a certain pattern of behavior. Insight in its most extreme connotation allows the individual to penetrate to certain existential cores that have remained hidden and distorted. This new knowing carries with it feelings of satisfaction and, at the extreme, exultation. These intense moments of self-awareness heighten the ego's strength and allow the commencement of changes in attitude and flexibility of behavior.

It seems relevant to note that it is the therapist's personality and idiosyncratic background that dictates his choice among the various group techniques. The decision to use one or other of the therapeutic approaches is not based solely upon theoretical grounds. Some individuals are "by nature" able to utilize a spontaneous interactional approach. Some are inclined to be passive leaders, others more authoritarian. There is little doubt that the "conductor's" own repertoire is a crucial influence on the symphony and its style of production.

The surprise is that patients do get better by what apparently theoretically are widely divergent methods. Reading accounts of the actual handling of groups, however, suggests that differences in method are not as great as they seem. The question of semantics is clearly in the forefront. Frequently, what one therapist may call an analysis of interaction is to another an analysis of insight. An example may help to illustrate the similarity of "insight-content analysis" to "interaction-process analysis." A young, good-looking psychiatrist entered a training group of six other therapists some seventeen minutes after the first session had com-

menced. He came in rather out of breath, looked inquisitively around the silent room, and then stated quite belligerently, "I am Dr. X from . . . and I am the Chief of . . . and . . ." The rest of the group complied for the moment, "going around" and introducing themselves for the second time. "What is the philosophy of the group here? What stage are we in now?", the new member asked loudly. What emerged during the remainder of the session was the group's anger and the scapegoating of the new member. By various overt and latent, verbal and nonverbal communications, the group developed a type of protective shield about the therapist and slung arrows at the intruder. Smirks accompanied by downcast eyes or raised eyebrows, silence to his questions and giggles by the women, and an ambivalent feeling in the therapist who felt the surge of the rival leader—all were present. Toward the end of the session the therapist inquired about the group's feelings and attitudes. Immediately, the sulking turned into overt anger against that "revered doctor who pompously was not interested enough to get to the group on time and then wasn't satisfied with anybody," and, "I don't like his superior tone," "there is something disgusting that I just cannot put my finger on." I called attention to the group's tone of anger and the presence of marked "stranger anxiety," "scapegoating," etc. The new member looked sad but also angry and chose flight, not fight (in Bion's sense) not returning for the afternoon session. After a three or four minute silence in the afternoon session, the therapist called attention to the drop in "tone" and "activity" of the group and asked for clarification. Feelings of guilt, sadness, and gradual mourning for the missing and lost member gradually appeared. Longing for the ambivalently regarded partial-member became apparent: "Maybe we should go and get him, he really wasn't so bad." "Maybe it wasn't his fault he was late," etc.

Was it the fact that the group was an on-going process and had already formed some interaction cohesiveness when their equilibrium was disturbed that led to anxiety and anger being engendered? Was it the fact that the "unconscious group theme," in Ezriel's (1950) terminology, was elicited because of the common stranger-anxiety, rival sibling response? Was it the fact that the new member protested at the here-and-now reality of a female-led group? Was it the fact that beneath the new members's antagonism to the leader there was not only rivalry but erotic undertones? Answers to all these questions are probably yes. The group responded with violence to the intruder, but part of this response was

evoked by the intruder, and the structure or organization of the group was strengthened by the members banding together and thereby lessening their own anxiety. It is of interest that the rejected member later came to the therapist to talk about his "traumatic" experience and what he felt had been a combination of "displeasure and cowardice." He added, "I realize it is part of me to create a storm wherever I go. My mother said I was always hard to handle." To me, it is the blending of these mutual understandings that leads to acceptable insights for leader and group in any multidetermined situation.

An example of insight via gradual working through in the midphase may be seen in the following: Mrs. N. S., an attractive, blond, "spontaneous" young woman of 27 had no difficulty interacting in the group. She participated in most discussions, showing empathy, giving advice, and speaking very fully about her problem. For many weeks she talked about her 4-year-old son who showed marked stranger anxiety, fear, and panic of staying in nursery school. Five other mothers and myself who made up the group listened and emoted with her. Shortly before Christmas, she reported that her son was making progress, and even though he put up a fuss each morning, she could leave him at the school. The following week she reported that the whole trouble was back. With prompting, she elaborated that, "Jeff didn't look so good to me. I thought he was coming down with a cold, so I decided to keep him home Wednesday and Thursday." One of the other members praised Mrs. S.'s preventive measure, and there was a discussion of the flu epidemic. I then commented on Mrs. S.'s anxiety and wondered if she could give more details. What gradually emerged was the fact that even though the boy really was not sick, she had kept the child home for the rest of the week, and the next Monday there was a return of the old panic and refusal to go to school.

The therapist pointed out that Mrs. S.'s behavior seemed to suggest both that she was not satisfied with the boy and that she had to prove to the child that her home was better than school. Deeper explanations were not given at this time. In later sessions it was learned that she had trained the boys (4 and 2) to go to bed at six in the evening. The group and I discussed her desire to have her husband to herself at night and to keep her sons close only to her. To deal with the situation she accepted the group's advice to give the boys a nap in the early afternoon, and in the following session she reported that the younger one had adapted well but that the problem child refused to nap or rest. Again, close

listening revealed that what in fact was happening was that the mother had put the youngest in a bedroom but kept the four-year-old with her in the living room, where she darkened the room, prepared a bowl of goodies, and watched T.V. This time I pointed out with strong emphasis that again she had won her battle and reintensified the relationship between herself and the son. "You make yourself and the setting so appealing that your son does not want to leave your side. You make him dependent on you for every gratification. At the same time you rule him and your husband." Mrs. S. paled, bowed her head, and said very quietly, "I know I should have put him in the other room, but I just forgot. It's funny you noticed when I said on the sofa. What I want to say is I had two miscarriages before I could finally have Jeff, and then I watched him like a hawk. I never trusted anyone to look after him, until it was too late." She then cried, "How can he ever get out of my clutches!"

The following weeks showed a significant change in Mrs. S.'s attitude. She rescheduled her children, and the family began to have dinner together. This woman had been able to play-act the good mother and convince the group. Only via interpretation (but not to the point where she became aware that she was seducing her child and substituting him for her husband) was she able to change her behavior.

Another example of insight occurred in a different group when a young woman suddenly began to have an asthmatic attack, something which had never occurred before. She pointed accusingly at a man smoking a cigar, something he had never done before. There was a great flurry in the group, and the members began to call for help. I instructed the patient to breathe slowly, and since she was unable to talk easily, she was given a pencil and told to draw what she wanted to say. She drew a man smoking a cigar and a small child. Soon she began to breathe more normally, and with a tone of complete disbelief she was able to tell us that she had drawn a man who reminded her of her father; she recalled his anger when she once had a "coughing fit" and that he had spanked her. The present interaction, connected with the realization that until now she had refused to face the marked anger against her father which had prevented her relating to men satisfactorily, started a change in this woman's object relations pattern.

Discussion often reveals that therapists utilizing apparently different modes nevertheless pay attention to the major parameters of psychic

functioning which allow defense alterations to mediate ego flexibility and change. In this respect group therapy ranks very high as a technique that allows a small society to engage in multiple clarifying, magnifying, and distillation techniques which gradually lead through insightful penetrations to alterations in ideation and behavior.

Criticisms leveled against insight-oriented group therapists include the following: they are too passive, too cold, too uninvolved, and too intellectually oriented. There is little doubt that group therapists have become more active and more humanized in the last years. Glatzer (1959) was one of the first to call attention to the therapist whose unconscious masochistic needs foster passivity and allow continual suffering of the patient. Others, including the transactionalists (Berne, 1960), did a great service in defining the games that the therapist himself engages in to maintain his needs for omnipotence, superiority, and the like. The group existentialists fought bravely against the intellectual parameter, gradually giving up transference interpretations and stressing feeling tones and engagement reactions.

On the other side of the fence, the classicists criticize and decry the interactionalists who, in their effort to be one-of-the-boys, surrender their leadership role, over-engage, use brash four-letter words, posture, abreact personal experiences, etc. The danger here is the overencouragement of acting out in and out of the group and the latent sanction given to rebel against authority models. There is also the conviction to talk "honestly" is an effective therapeutic device.

These extremes have been painted expressly to suggest that followers of neither camp would consciously engage in such manipulative devices but that the issue of countertransference is a very relevant one. The degree to which the therapist expresses his own feelings is a critical way of defining group goals. At the appropriate time the therapist may well initiate increased exploration by sharing his identification with the group mood or conflict, but too much flooding by the therapist makes him a target for scapegoating. The danger of overexposure and exhibitionism by the therapist must be considered as well. In my own groups, if personal questions such as, "Who is your husband?", "Do you have children?", "How old are you?" are asked, they may or may not be answered according to the situation, and at all times the patient is asked why he feels he ought to know these facts. Toward the end of treatment, reality orientation and closeness are much more allowed, but prior to that, lack

of distance by the therapist blocks many patients because of their erotic fantasies toward the therapist.

From the point of view of societal norms, the consequences of the sanction of bizarre acting out by a professional must be kept in mind. We must know what we are doing. But the freeing of both libidinal and aggressive drives are part of the responsibility of the therapist, and with certain ages or symptoms, group techniques have to be altered; family and child therapists for instance, have to initiate more activity and interaction.

Coons (1967) in a recent article stated that, "Evidence converges to suggest that insight cannot be properly considered to be the crucial condition for behavioral change in psychotherapy . . . adjustment to reality depends on opportunity for the repeated trial-and-check of individualistic expectations. In psychotherapy this implies opportunity for interpersonal interaction in a consistently warm and accepting social environment." These statements were based, in the main, upon work done by the author in 1957 in comparing interactional and insight group approaches, with the results in favor of more change being produced by the former. In the original study (Coons, 1957), however, the sample used was that of chronic schizophrenics in a state mental hospital. It does not seem surprising, therefore, that "reality adjustment" was not achieved by the classic insight approach. An anaclitic group method, as reported by us (Azima, 1958, 1961) some time ago, proved to be a very favorable method of inducing change in chronic schizophrenics. Thus, it seems unwise to stigmatize insight as a useless technique when the therapeutic approach does not coincide with the ego resources of the patient group.

Emphasis on more interaction and less insight, and vice versa, must to a large extent depend upon the psychiatric syndromes represented by the patients and the setting of the group. Groups in prison, L.S.D.-takers, and hippies are quite a different kettle of fish from married couples, latency-age children, and jet-set patients. Neurotics, psychotics, and patients with character disorders require specific modifications of technique. In all efforts there must be a consistent, responsible effort to identify grotesque behavior patterns that are being neurotically perpetuated. Whether we use the concepts of mirroring, reassurance, group assumptions, group tensions, games, engagement, etc., the search is for a successful decoding of the behavior patterns.

Briefly put, my point of view is of the desirability of a juxtaposition

of insight and interaction, not only in the usual vertical dimension but also in the horizontal one. It seems, at this point in time, just as fruitless to build an edifice without historical foundation as it is to erect a super-structure of many rooms. At what point an interactional confrontation mediates an insight useful in bringing about group and individual change is a meaningful area of research for the future.

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The Case for Interaction

JOHN J. O'HEARNE, M.D., and
DONALD D. GLAD, Ph.D.

Iᴛ ᴡᴀs ᴡɪᴛʜ sᴏᴍᴇ hesitancy that I accepted the invitation to present to this panel the case for interaction in group psychotherapy, for I doubt that any school of psychological thought can claim me exclusively. I began working with groups twenty years ago with the junior author of this paper under the administration of a psychobiologist who saw to it that we were introduced to psychoanalytic viewpoints in our training. I had very little pruning as I grew into a group psychotherapist during my residency and later, except for a Freudian analysis and supervision by another Freudian analyst. I have been particularly influenced by the writings of, and my contacts with, Milton Berger, Max Rosenbaum, Hugh Mullan, and George Bach and by the many therapists who have led workshops at the annual meetings of AGPA; by my experience in T-groups as both participant and trainer; and by the writings of those existentialists I can understand (Hora, 1956; Mendel, 1964; Mullan, 1957; Mullan and Rosenbaum, 1962; Mullan and Sangiuliano, 1960, 1961; Sutherland, 1962; Warkentin, 1956; May et al., 1958). Consultation and research with the co-author of this paper for the twenty years we have worked with groups, together and apart, have been invaluable. His book, *Operational Values in Psychotherapy* (Glad, 1959), helped to clear

my confusion often. (He served as consultant in preparation of this paper, but all first-person comments refer to the senior author.) Perhaps a summary of the credo I have evolved from such disparate sources is in order.

I believe that interaction in groups often makes it possible to bypass elicitation of insight in favor of enlarging ego boundaries and making it more likely that the patient will risk new action which may lead to increased present and future satisfaction. I believe that once the patient risks interaction, a reciprocal process, with one or more other persons, he learns that relationships with their feelings and activities are not as dangerous as he had feared. As he risks new relationships, he finds them less dreaded and assumes responsibility for risking other new ways of relating. His new behavior elicits more positive feedback, which tends to reinforce his changes.

I believe that identification with the therapist is highly important in group psychotherapy, and, furthermore, I believe that the patient has to be taught how to be a patient. I know that my patients may use me as a model, and I touch, teach, try to understand, make jokes, occasionally state my feelings, etc. I am the most expert *person*, as well as the most expert therapist, I know how to be when I am working with a psychotherapy group.

I believe that regressive transference neuroses are usually to be avoided in this type of treatment, and I work actively toward forestalling their development. (Of course, they sometimes do develop in spite of my being anything but a neutral screen.) I may repeatedly demonstrate the influence of the unconscious in order to show the patient how he will have to be alert after finishing treatment to such influence, but I remind him that he must still choose what he is going to do about it. I try to get him to master traumatic potential by living through the dreaded relationship, feeling, or action in the group. I emphasize how his present choices influence his future history.

I believe the patient must be reminded from the beginning of his autonomy, my lack of omniscience, the lack of certainty in our therapeutic venture, but of my willingness to try to help him find his own road through life. These factors, plus emphasis on learning new ways— not mainly unlearning old ways—and emphasis on growth, risk, and responsibility for choosing, reduce the power struggle between patient and

therapist, as well as help to minimize severely regressive transference neuroses and acting out outside of treatment.

I believe that most of my patients need to learn that aggression can be constructive, not just destructive. Most of them need to learn that it is all right for adults to play and that men and women can relate in ways other than purely sexual. I hope to be able to help them to seek new experiences rather than merely defend against them and to show them that authenticity does not have to be equated with pulling down the psychic zipper. I hope to be able to help them learn that life itself, like psychotherapy, is a creative venture with plenty of the anxiety of doubt and creation.

Now, how is it done?

I can refer you to books and articles about traditional approaches or about the existential or about the experiential or I-thou influences on my practice about the same way an oil painter can refer you to books on the chemistry of oils and the physics of color. Such references will not show you the process or the finished product. I shall make an effort to show you some of the process by ample use of examples, but I am uncomfortable about lifting them out of their contexts. To many, these examples will seem like wild therapy. To make it worse, I have deliberately avoided using clinical samples which show steps leading to the development of insight in a more traditional sense. I need to comfort myself with such words as those of Bennis (1963), who reminds us that, ". . . like the search for truth which never reaches its goal yet never can be abandoned, the endeavor to articulate an experience can never succeed completely." Birdwhistell (1963) contributes: "Focus upon the actor and the reactor serves only to obscure the systematic properties of the scene, whether viewed from the sociological or the linguistic-kinetic-communicational point of view . . . We now know that neither words nor gestures are the essential units of the communicational structure."

A clinical illustration may help demonstrate some of these points. A bright, forty-one-year-old social science researcher (I'll call him Thinker) presented himself for help and said, "I'm interested in increasing the kind of personal sensitivity that would help me in my work with groups. I am also interested in behavioral therapy which I know little about but think we ought to be able to somehow add group therapy and behavior therapy to effect powerful changes in people . . . Sex is my chief joy except perhaps for enjoying sharing viewpoints intensely . . . I don't

like to believe that I'm not warm." He had seen four different individual therapists in two different cities intermittently for ten years. Interviews and psychological tests indicated that his characteristic approach to life was obsessive-compulsive intellectualizing, isolating thought from affect, approaching interpersonal relations via intellectual, competitive activities and through getting authorities to be angry or disappointed with him. As we approached treatment, he said he would probably be fired soon from his job. Since I knew he would set me up as an authority, I told him I needed some help from both his wife and someone in a position to evaluate his work. After I had talked with them, I confronted him with variations between their views and his view of himself. Though his personal relations were few and his Rorschach full of de-humanized figures, he had felt and functioned better in different training groups and more poorly in one-to-one relationships. Interviews and the Leary Interpersonal Checklist showed his view of his ideal self and his ideal wife as being almost identical and his view of an ideal therapist as being almost a nothing. I reviewed these facts with him and asked if he thought treatment on an individual or group basis seemed a more logical choice. He grinned and said he thought he would get a lot out of individual treatment but that the group seemed more logical. I told him that we could keep open the matter of our working together alone and asked him what he thought he could get out of group treatment, as well as what he could contribute. The latter question surprised him. I also asked what he thought he would quite naturally and characteristically do to maintain his status quo and defeat efforts at treatment. He again grinned and said, "I think I'll sneer at one of your goofy interpretations." I laughed and said, "I'll bet you sneer at lots more than one of my goofy doings. I want to tell you, even though I expect you to have trouble acting upon it, that if you will show us how you feel, then we'll not only get a chance to know you better but a chance to look into your mirror and see what facet of each of us you reflect. You'll tend to think that your sneering or hostility will be destructive to us, but I hope you can learn that aggression doesn't have to be hostile all the time; that without aggression, we solve almost none of our problems in living. Do you expect to see any of my problems in living?" He replied, "I'm sure I will." I said, "You are right, and will you give me a chance to look at how you see me and my problems in living or will you make me a lonely god on a distant throne?"

I hope this excerpt gives some idea of the attitude with which I approach a patient's entry into a treatment group. Now, a vignette of what this patient encountered in his first group session may give some idea of my approach to treatment. I am convinced that I cannot impart to you the history, stage of growth, climate, etc., of this group, so I shall not try.

My office is oblong and has three different types of chairs and a three-cushion sofa at the wall farthest from the door. In the next to last session before Thinker joined us, Belle told of discovering that her husband was having an affair with her best friend. Though she cried, we questioned the depth of her feeling. This puzzled her. I thought she might recognize her grief if she were physically closer to a man and asked her if she would like to sit between me and Francis on the sofa (where we already sat). She thought for a while, then left her chair to come sit between us. She sat still for a moment, then let go with her grief, and Francis put his arm around her. She took his comforting for a while, but soon made her usual smile to hide trouble and said, "I always did like a man who wore a white shirt. My daddy even wore one when he went out into the fields." While Belle sat there, I, of course, touched her. At our next meeting, one week later, she told of having recognized sexual feelings toward me for the first time and remarked that she was happy she could feel these feelings since she knew everyone was supposed to fall in love with his psychiatrist. I told her that everyone was supposed to be honest with his psychiatrist, as well as with others in the group, and that if he were, he would find love, hate, fear, sex, grief, etc. I then told her that I'd considered very seriously before beginning to work with her the fact that I found her very attractive, and I asked if she thought we could handle our feelings now. She did.

The next session saw the introduction of the Thinker. When the chairs in the office were filled, I sat in the middle of the sofa. The next patient to enter was Martha, who looked stunningly attractive. She looked for a seat and, seeing none except near me, laughed and pretended to dive for the sofa. Diana, who had been afraid to feel warmly to me, then got up and came to the other end of the sofa, sat and smiled at me and Martha. Thinker had seated himself in a chair near Diana's end of the sofa.

Diana told Martha how much she'd liked Martha's husband and how surprised she was when she met him the night before; she'd expected

an ogre. Martha told of how anxious she was that he'd embarrass her socially; she was always afraid he wouldn't do the right thing. I looked at Thinker, who showed no expression. Diana and Martha talked of an ex-group member, identifying him as such to Thinker. Helen said to him that she remembered how she felt in her first session when the group talked about ex-group members and their past history together. Belle said she thought we always talked about old times when a new member came. Diana asked Thinker if he were a doctor. He replied, "Not a medical doctor." I asked Diana what made her think of him as a doctor. Several said he looked like he was thinking so hard and yet seemed clinical, detached. Someone said, "Like Dr. O'Hearne," and all laughed except Think (by now I'm feeling more friendly to him). At this time I had stretched my arms out over the tops of the two adjacent sofa cushions. I turned to Diana, who had, in prior sessions, said she was afraid of my warm feelings, and asked her if she were afraid now. She said, "No," and I said, "I'm glad you could get out of your chair and come over. You seldom took that chance at home." She said, "I never did." I replied, "Time for change." Martha pretended to be in a huff, turned her back on me, but drew closer to me while laughing. I put my arm, momentarily, over her shoulder and said, "Do you want all my attention?" As we moved apart, Helen told of having cut off a sado-masochistic relation with her boy friend when she recognized that he treated her like Grandma had treated her before. Grandma had punished her to the point of tears and would then rock her forcefully, holding her, and angrily tell her not to cry. Here Helen cried, and I said, "But, now, with us, you aren't being rocked and you can decide when to stop crying." She did stop and said she thought the boy friend was crazy. I said he wasn't but that she might decide it was crazy for her to continue going with him or Grandma or whoever he was. Think's forehead was working overtime, and he made a statement which mainly echoed mine. He glanced at me and I nodded back. His only other few comments during the session were of similar efforts to help others, and as he tried to help, he seemed to relax a little. Belle leaned forward, ignoring the two women flanking me, and told of recognizing during the week that she and her husband each kept a large distance between them, like Helen and her boy friend. She mentioned my wife, whom she had known prior to therapy, then hesitated. I asked if she thought it necessary to stop or if she could risk talking about my wife, my family, and me. I said I'd con-

sidered the fact that they knew each other before putting her into a group and that I'd trust her, my wife, and me to look at any of the relationships that were necessary to investigate. (Contrast this with a therapy aimed at transference neurosis, where treating such a person who knew my family might well be contraindicated). She hesitated, took a deep breath, and then told of having felt some resentment about my wife's trying to help her. She felt that this kept them apart at times. Then she showed annoyance at herself, her husband, and my wife for the distance between herself and them.

She went on to say that she had had a dream of being in my living room, though it seemed absolutely huge. Diana and I agreed that the scale suggested she was looking at something as a child. Helen laughed and said she had at first thought how nice it would be to be my wife but she knew I would want a close, even intense relationship, and she would rather have one in which she could come in, be greeted and held for a while, then do what she wanted. She realized this was basically how she was living with her husband and said it was no wonder that they couldn't get close.

Others in the group talked of some of the ways they put a large emotional distance between themselves and their loved ones. They also talked of several of the men in the group becoming warmer, more spantaneous, at lunch after they left the meeting than while they were here. Some group members laughed and said there must be something about me that inhibited them. I agreed it could be in me, in them, or the setting.

Think had remained very thoughtful but almost silent during his first session. I turned to him and said, "I don't know how long you will tend to keep you and/or me on the throne, but I'll be glad when we get to know you better. I think that, like J.C. and Francis, you will be able to relax better when you know that you are the one who chooses how much of you we shall get to know." Then I turned to the group and said, "Think hasn't said much today, but I feel fairly comfortable with him. How about you?" The majority said he looked interested and somehow they thought they might be able to trust him fairly rapidly. I said, "Let's see how we do together," and ended the session.

Another illustration from another group may serve to demonstrate a method of dealing with a patient's transferential distortion by insisting the patient examine what is going on between us now, rather than elaborating the historical antecedents for the distortion. Marie was an

attractive woman who succeeded in getting some attention and concern from the group but she had also been told that she prattled on without saying anything and that people lose interest in her when she does this. In one session, she became annoyed with me for paying so much attention to someone else and said she thought I deliberately slighted her to favor other people. Someone said, "He's not your father." She replied, "I know he's not, but he sure acts like him sometimes, always paying more attention to the others, or at least it seems like he prefers some of the rest of you to me, and that does remind me of my father." She looked more petulant than angry, and I said, "I wonder if there's something going on between us now that you want to leave where we are now and go back to seeing me as a father?" She repeated what she'd said before, and I again asked what was going on between us. She smiled and said, "Well, I always have thought you were kinda cute. And, to tell you the truth, I have always been more attracted to you sexually than to any other man in the group." I smiled back and said, "Well, then, can't we stay in the present and deal with it? Okay, so we're sexually attractive to each other; now what?" She again grew petulant, talked again about being slighted. I asked, "Like father again? You're leaving me. What about our sexual feelings?" Another patient told her: "Marie, you're acting like a love hog again. You're a lot like me; we're both love hogs. But I am doing my best to set that aside and be able to love my husband like a woman, not a child. It seems to me you are willing to do all the work of a wife if you can only get treated like the cutest child."

Fantasies and nonverbal behavior often reveal deeper psychic function so much better and more accurately than words that I find them very useful. I have used nonverbal interaction in groups much more after seeing the beneficial results obtained from them in various T-group situations. I shall try to demonstrate some of this in the remaining three behavioral samples.

An illustration which may show an advantage of interaction over verbalization occurred in a group in which I was treated warmly but deferentially by a young man who felt he should never succeed because his father hadn't. He had almost never expressed anger in his family or in the treatment group in an assertive way. He used much denial and intellectualization. He started one group session by saying, "I sure was angry with you in my last individual session. You acted so sleepy and bored." I replied, "I was. I told you then that I was." He answered, "I

know, but I couldn't feel my anger about it until later." I said, "You smiled all the way through." He said, "I couldn't feel angry then; I did later." I asked, "Are you angry now?" He answered, "Of course." I replied, "I hear your words about anger, but I don't feel it." He slumped his shoulders, smiled, sat with his legs wide apart, and assured me of his anger. I asked if he trusted himself with his anger and he said he did. I said, "If you trust yourself with it, I will too. Let's try something. How about coming over here and placing your fist gently on my jaw?" The group laughed. As he doubled his fist, I said, "Gently." He placed his fist gently on my jaw and suddenly his smile left; he tried to get it back but couldn't. Tears formed in his eyes, and he pressed hard on my chin. He clenched his other fist, and I asked him if he wanted to put it on the other side of my chin. He very seriously said, "No, I think I can control it, but I'm not sure." He pulled it back a bit, kept it clenched, and I said, "Can you feel anger now?" He backed away, nodded his head, and said, "Now I know what it feels like. That's *real* anger." The whole group was impressed with our trust. In the next two weeks, he stopped telling us how much he had changed and was improving; instead, he did something about his hostile-dependent relationships at home.

A small sample of the use of fantasy might be appropriate here. As an exhibitionistic schoolteacher talked of his accomplishments, I began to smile. Someone saw it and inquired. I said, "I had a fantasy. I saw a huge penis horizontally and then unfurling from it an enormous banner that says, 'I am a good teacher, too.'" All laughed. The teacher then talked of realistic accomplishments and of his anxieties, and the next week he told of remembering this fantasy and laughing about it all week, saying that it had helped him a lot with his anxieties. In a subsequent session, a previously rigid, unimaginative young man said to the teacher, "I had another fantasy about your penis. I thought of you pulling it out, and it had eyes on it and looked all around, like it was looking for something." The teacher replied, "You're exactly right. It's my only contact with the real world. If they don't see it, I'm nothing. If they don't feel aroused, I feel cheated. I have no face unless somebody looks at me."

In rare sessions lasting twelve or more hours with pre-existing psychotherapy groups, nonverbal activity assumes an even larger part of my approach to therapy. Two brief excerpts may help clarify this statement. In one such session, a young man again told of feeling like he was always

deep in the well, looking up at everybody else in the world; he said that he always felt far beneath everyone else, that he felt all wrapped up in himself and unable to get free. I asked for a sheet, asked him if he would be willing to try literally to get all wrapped up, and he agreed. We wrapped him snugly, so that only his head and neck were out. Then I asked if he would trust us to lower him to the floor on his back. He thought before saying yes, and his knees buckled a bit on the way down. He commented on this as he lay with his eyes closed: how difficult it was to trust, how he didn't know if he'd ever trusted anybody in his life. Occasionally, he raised his head to look around, then lowered it and shut his eyes. I asked if he wanted his head elevated. He agreed, and I asked if he'd trust me to hold it. As I sat in a chair above him, with my feet on either side of his ears, my hands forming a cradle under the back of his head, I thought of Card IV of Rorschach, but I commented on the fact that he soon relaxed his neck muscles and let me hold his head. He said he didn't think he ever could trust anybody that much. When he asked to get out, the group members gently unwrapped him. He stood in the center of the room and said he was surprised he could trust anybody as much as he had trusted us and that he had never felt so big in his life. Then he suggested that a scared, withdrawn woman, Michelina, try it. She did, in a more relaxed way, showing virtually no anxiety or distrust. The group was stunned at how comfortable she seemed. She closed her eyes. One man shuddered and said she looked dead. Annette, nearing termination of her therapy, began to cry, knelt down, pressed her face against Michelina's, wept and pleaded for her to wake up and try to get out of the cocoon. To our surprise, Michelina did manage to get one arm out. She put it around Annette's neck, and they wept. Annette said that while she herself had been living in a cocoon like that, she had missed so much and felt so lonely and scared that she hoped Michelina would not waste so much time in a cocoon.

I realize that the examples I have given are easily subject to misinterpretation, but I hope they are taken to be samples of how one therapist uses himself in interaction with his patients. I know it would make for livelier discussion if I said that I find no need for insight, only for interaction, in group psychotherapy, but that is far from true. In this paper, however, I have emphasized the interactive process and tried to show something of its reciprocal nature.

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Summary

DONALD D. GLAD, Ph.D., and
HELEN E. DURKIN, Ph.D.

Both speakers include both interaction and insight as part of their method but differ as to which process is the chief agent of therapeutic change. Dr. O'Hearne believes it is the reciprocal action or influence between members and therapist. Mrs. Azima considers it to be the gradual development of insight, in the context of emotional interaction, into how past experience has intruded upon the present and converted potential real relationships into neurotic transference.

Both agree that nonverbal insight may occur, but the "interactionalists" consider this an end in itself while the analytic group therapists believe it to be of minimal use unless it is converted into conscious understanding. The latter believe that cognitive learning must be part of the process if the change is to be transferable to a wide range of situations.

Both work for spontaneous emotional interaction among the group members, but interactionalists believe interaction to be the agency for change while analysts believe it provides only the climate for change.

Both sides view the therapist as the central figure and consider an empathic attitude as a major qualification. They differ as to how the therapist should use himself. Dr. O'Hearne uses himself as a catalyst and a model. He expresses his emotions, teaches his values, and employs touching and action. Mrs. Azima adheres to the neutral position. She tries to understand the members' dilemmas. By analyzing transference and resistance, she works toward bringing about self-understanding. Insofar as possible, she leaves it to the patients to choose their own values.

Therapists of both schools try to be as fully aware of their own feelings as possible, but the interactionalists convey these feelings to the members in a mutual interchange while the analytic group therapists try to keep their own feelings out of the interaction except insofar as they aid in understanding the patients' motivations. During sessions, they focus on the feelings and motivations of the members.

Both avoid pervasive regression and the elicitation of history for history's sake. Dr. O'Hearne makes interpretations strictly in the here-and-now. Mrs. Azima consistently makes use of relevant historical material for the purpose of separating the past from the current influences on behavior.

The good for both sides is behavior change, but Dr. O'Hearne encourages, in a very direct way, an existential attitude, with risk-taking and responsible action by the members. Mrs. Azima works toward basic structual change, believing that, as a result, the patients will become able to take risks and assume responsibility for their actions and values.

Both sides consider group therapy to be a learning experience, but the interactionalists think that learning takes place primarily through positive group experience and feedback, while the analytic group psychotherapists believe that because entrenched obstacles (defenses) to learning must be eliminated before the patients are able to learn from positive experience, removing these obstacles by analyzing them out takes priority in the therapeutic process.

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Discussion

GEORGE VASSILIOU, M.D.

IF I WERE TO choose a title for my discussion, I would call it "Group Psychotherapy and Common Sense." This may sound cynical but remember, please, that I come from an area of the world where some of us are trying to introduce group techniques in countries in which there is little public awareness of psychodynamic theories. Often people, even colleagues, when they hear our jargon, are reminded of that Nastradin Hodja story: Hodja was coming back from the fields on his donkey when, at the entrance of the village, he saw his friends quarreling. "Friends," he said, "what's this all about?" "We are quarreling," they said, "about where the center of the earth is?" "Oh!" Hodja said, "it is exactly under the right foot of my donkey." "Well, well," they said, "can you prove it?" "It is simple," Hodja replied, "If you don't believe me, measure it!"

Common sense warns that since "insight," "interaction," and numerous other terms in our field express theoretical concepts, it is inevitable that: (a) even when the terms are used "correctly," communication will be difficult because their "correctness" varies from scholar to scholar depending on the "orthodoxy" or "unorthodoxy" of his theoretical assumptions; and (b) when used loosely, the result will be nothing less than parataxic communication. On the other hand, common sense says that since we do not yet have generally accepted views concerning personality functioning, malfunctioning, and therapy, we should not be that doctrinaire and argumentative.

The fact is that, at such an early phase of development of our field, we are forced to undertake a task nothing less serious than therapy, treating patients, suffering human beings. In the face of this tremendous practical, applied task, each therapist has to mobilize whatever he has—theoretical assumptions, qualitative observations, any kind of data—and build a therapeutic system and a technique. He practices it, teaches it, defends it. As long as he is absolutely sure about his system, he can apply it with the same confidence as an internist draws a blood sample, orders culture and sensitivity tests, and recommends drugs. Lacking "objectified" indices concerning therapeutic results, he has to be confident that his technique is therapeutic, and in the event of poor results, he must believe that it is something else which has prevented it from succeeding. From the moment the therapist starts doubting his system and his technique, he inevitably becomes a failure or a fraud as a therapist.

It is at such critical periods of scientific development that it is required from scholars that they transcend themselves and, in an advanced state of intellectual maturity, break the walls of closed ideological systems, not in a nihilistic, destructive fashion but creatively, using sincerely whatever they find to work with while remaining open and receptive to new ideas.

It is a very difficult state to achieve. One pays for it with attacks, hostility, and isolation. Thus, it is not surprising that most scholars prefer the relative tranquility of a closed system. But the latter makes it inevitable that the scholars will become involved in dogmatic disputes with colleagues representing other closed systems and that each will become progressively and increasingly doctrinaire. It is inevitable that in this way artificial dichotomies (either/or) will be created, leading to endless arguments. Closed ideological systems are eventually doomed, but a dreadful process first occurs. An idea, in order to advance socially, has to become an organization, and at a certain point in its development the organization is tempted to falsify or even to kill the idea that generated it in order to survive as a social system, as an organization, as a structure. Political parties, churches, institutions, institutes, universities, scientific associations—all suffer on account of this tragic process.

Common sense warns us that we cannot comprehend a malfunctioning unit without previously comprehending it well in its functioning form. Nevertheless, following the splendid psychiatric tradition of viewing normalcy as a deviation from pathology, we remain unaware of what

the functioning form of our subject matter is, or if somebody tells us that there are research data about it, we fight the data. Presently we talk about a rapprochement between "group dynamics" and "psychodynamics" as if these were mutually exclusive entities. We forget that our colleagues working with "nonclinical groups," the so-called "group dynamicists," are studying nothing else but parameters of our subject matter in its functioning form. Why do some of us fight this knowledge? Why have some of us become "allergic" to the words "group dynamics"? It takes very little imagination to hypothesize that the reason is that such research data bring some reality into our "speculations." Entangled in "metapsychology," we are so thrilled that we forget that it can be useful only to the extent we use it for the development of working hypotheses. From the moment we take it as reality, we behave like Nastradin Hodja when one of his neighbors went to his house and asked for his donkey to go and pick up some wood from the hills. "Yes," Hodja said, "by all means, but you see the donkey is not here. He is in the pasture." At that very moment the donkey started braying from the barn. The neighbor, surprised, said, "But, Hodja, the donkey is in the barn!" and Hodja, in complete indignation, said, "Look, my friend, do you believe me or the donkey?"

We have a tendency (or temptation) to place theories above reality. And we easily forget that theories are just "working hypotheses" and only as such can they lead us to ever closer approximations of reality.

Naturally, we shall keep disagreeing in theory—a continuous dialogue is the very prerequisite for scientific progress—but there are indications that, in practice, our differences are not as significant as we let each other believe. For example, one of my good friends is a prominent theorist and a competent group therapist. Theoretically he says we differ much. But when his students observed me conducting a therapeutic session, they told him, "We don't know who is copying whom. Do you copy George or is George copying you?" *The significant thing is that neither of us had ever seen the other conduct a therapy group.* Since then I have repeated this small "experiment" with a number of experienced colleagues in different countries. I ask them to read a detailed description of Transactional Group Image Therapy (Vassiliou, 1968), form an opinion about the approach, and then observe me in an actual session. Invariably, they report different, even contradictory, conclusions.

Such incidents and observations suggest what might be called a hypothesis of assumed differences. In each therapist, psychodynamics, cosmotheories (views of the world) and biotheories (views of everyday life) are processes leading him to the formulation or acceptance of certain theories and to the development of a personal style of therapeutic intervention. Inevitably, he considers his school "different" from other schools. Caught up in the stereotyped expressions of his "school," he perceives the other's stereotyped expressions as "different," while the other does the same, of course. It does not occur to them that their verbal abstractions may describe the same processes in different terms; the difference in description is assumed to connote difference in essence.

This view has been expressed about psychotherapy many times in the past, but I do not see why it cannot be tested in coordinated research among large centers. Such an effort will come up against the desire of each center to reserve for itself the charisma of "orthodoxy," but let us keep in mind that other institutions have paid dearly (up to one hundred years of wars and up to the liquidation of total empires) for the sake of "orthodoxy." Is it really true that as human beings we cannot learn from history?

But let us focus directly on the Panel. It was heartening to see the openness of the papers presented. Disagreements exist, but there is an openness. Let us, please, not be impressed with the "assumed differences." I ran two small "experiments" in Athens on the papers we heard and the results were not only didactic but therapeutic. I copied passages from the papers and gave them to an associate, telling him that these passages were excerpts from two differing, opposing papers and asking him to sort the passages. It was difficult, for many passages from the one could be harmoniously placed with the other.

Then from Dr. O'Hearne's paper I read to an associate two incidents without disclosing to her that it was the same therapist who was acting in both. After hearing the first incident, in which the therapist put his arm around a female patient, she said, "It's horrible. It's Peter Sellers in his best moment in *What's New, Pussy Cat?*" After the other incident, in which the therapist invited the young male patient to place his fist on his chin, she was deeply moved. "That's a masterful piece of therapy," she said.

When I disclosed that it was the same therapist who had done both actions, she said, "Oh, no, it can't be." I am sure that there were just

such reactions among the audience today. So let us go beyond the "assumed differences."

My view is that both terms around which the Panel is centered connote processes which cannot be separated in the total group transaction. I am talking about "transaction," not interaction, and I use the term as it was defined by Dewey and Bentley and then introduced into psychiatry by Grinker, Ruesch, Spiegel, Shakow, Jackson, and others. In this view, "transaction" connotes that one system is in a process with another system and they mutually alter each other. When you throw a piece of wood on another one, you have *interaction* between these two objects. But when the wood is burning and you drip water on it, the dripping water changes the burning wood and at the same time and by the very same process the burning wood changes the dripping water (it evaporates it). You have a transaction between two systems, burning wood and boiling water, which enter into a process. The fact that for didactic, descriptive, academic reasons we are forced to label the processes distinctly does not mean that we can so divide them in actual life as to be able to focus exclusively or even primarily on one of them. We cannot possibly permit ourselves to become so deluded by theoretical constructs as to forget that when a therapist enters into a grouping situation with a few other people, he, as a subsystem, enters with all other subsystems, the members of the group, into a number of interrelated processes leading to therapeutic transaction.

The role of the therapist is to optimalize this transaction in its totality. The very moment he operates on the so-called "intrapsychic" processes of one member, by the very thing he does, by the very fact he does it, he triggers a number of feedbacks which alter the on-going processes and the total group transaction.

It is an outright distortion of the therapist's role to conceive of him as a friendly "stone statue" making encouraging but monotonous noises. It is often overlooked, I am afraid, that "minimal activity" means actually silent but expert, skillful, watchful waiting for that brief but crucial moment that will not come again, the *kairos* of ancient Greek philosophy, when maximum leverage can be applied; we call it confrontation, interpretation, etc. It is in this context that the seemingly paradoxical statement "good psychotherapy is as indirect as good surgery" makes a lot of sense, and it is in this context that we prefer to use the term "optimal activity instead of minimal activity.

This point of view also throws new light on the axiom that it does not matter so much what a therapist says or does as what he really is.

The life event is that a real human being, the therapist, with his unique personality is encountering in the group situation other human beings, each with a unique personality of his own. This life event cannot survive artificial dichotomies. The therapist, for instance, cannot overlook that the real interpersonal processes developing in the group are fused with transferential elements. If he deals only with the transferential, he only serves indirectly, if he succeeds in serving at all, the most important aspect of his role, which is to guide, help, and assist his patients in learning and developing interrelational patterns more fulfilling of their realistic goals and needs. These patterns do not grow spontaneously; if they appear to do so, it is either due to the fact that the therapist fulfills this task unknowingly or that someone, somewhere, is doing it and thus helping the patient.

Acceding to the reality of this life event, the therapist cannot permit himself to artificialize the group transaction. Thus, the famous dilemma: shall we focus on the "here and now" or on the "there and then," becomes nonexistent. It is, of course, impossible to separate present and past. All of us perceive this moment through the past and the past through this moment.

By talking about spontaneous transaction do we imply that group therapy should be a free-for-all? Do we intend to confuse roles during group therapy? Quite the contrary; roles should always remain clear-cut and distinct. It is ill-prepared therapists, not well-integrated personalities, who contaminate spontaneous transaction. Due to their problems they lose their firm grasp on reality and, consequently, what helps their patients and what does not. They forget that the sheer reality of the therapeutic contract makes revelations about their personal past and present problems in most instances incongruous, except in certain special, extraordinary circumstances which are outstandingly dramatic in the group transaction and should not be routinized. It should be noted, however, that this is different from the therapist supplying feedback to the patients; to the extent that this is therapeutically required, he reflects the feelings which they trigger in him at the moment.

The therapist engaged in spontaneous transaction will instigate more transference processes, but he will do it knowingly and with the explicit purpose of facilitating, uncovering and working through processes.

In short, the therapist should assume, fully and energetically, a catalytic role. He cannot expect either individual or group processes automatically to reach the therapeutically indicated optimal level. They will soon reach a ceiling, short of the optimal level. The subsystem which is supposed to raise the ceiling of group transaction is the therapist.

Such a perception of the therapist's role puts an even greater emphasis on the axiom mentioned before that what really matters is *what the therapist is.*

Undoubtedly, group therapy will progress. Better theories will appear; tools for research and methodologies able to actualize them will be developed. I am quite optimistic about the future of group therapy as a scientific discipline. Despite my optimism, however, I feel a need to remind myself of the old Diogenes story. A rich Corinthian had invited the philosopher to his villa. He showed him the mosaics, the carpets, and the silk curtains and invited him to admire them. Diogenes expressed his deep admiration for the artistry. Then he turned around and spat on the man's face.

"Diogenes!" the shocked man said, "why did you do such a thing?"

"Well," Diogenes said apologetically, "you see, I had a need to do it and I looked around, and unfortunately I could not find a dirtier place to spit on."

One might ask on what should we focus: better therapies or better therapists? I would again answer transactionally. It cannot be one or the other. It must be better therapies for better therapists for better therapies and so on.

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Concluding Remarks

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As I LISTENED TO our speakers and to the lively discussion with the audience, I was struck by how well we seem to be able to "hear" one another. Our aim, of course, was not necessarily to come to agreement but to clarify the real differences between us and to distinguish these from the stereotypic distortions to which such debates are prone. The harried old accusation that analytic group therapy amounts to no more than intellectualizing—as contrasted to applying intelligence and knowledge—was not heard, nor were the experientialists' innovations brushed off as mere irresponsible acting out by therapists and patients. Instead, it seemed to be clearly recognized that Mrs. Azima, a group analyst, was indeed in touch with her own feelings, even though she did not express them verbally, and with those of her group members; and it was accepted that her interventions consisted of a concerned attempt to utilize available rational ego functions in order to understand irrational motivation and behavior, to separate out the "there and then" from the "here and now" whenever the long finger of the past interfered with present relationships. Similarly, it was generally recognized that Drs. O'Hearne and Glad were experimenting with new ways to gain more direct and quicker access to impacted primitive emotions, defenses against which are only very slowly worked through in analytic group therapy.

There was obviously a great deal of overlapping between the two schools of thought in their reliance on interaction and insight. But real

differences emerged which revealed not only disagreement about the relative therapeutic value of emotion and reason but substantially different views of what constitutes the therapeutic process itself. Thus, in analytic group therapy, emotional interaction is the necessary context for insight; in experiential group therapy it is the major therapeutic agent, while unconscious insight is the sufficient, if not superior, by-product of the process. This confidence in spontaneous experience in the here-and-now as the mutative factor stands in contrast to the analytic reliance on analyzing resistance, working through, and using history. No, the two schools may remain good neighbors but marriage is out of the question because of religious differences!

However, it seems to me that in the course of continued debate the two schools may well come to serve as safeguards against each other's pitfalls. Psychoanalysis is grounded in a complex conceptual framework which is sometimes threatened with self-alienation by the very practitioners who seek to bring it to perfection. Group analysts inherit the condition and must avoid becoming so engrossed in technique that they lose touch with the spirit of the method, its essential human context. Those who become increasingly knowledgeable and precise in making interpretations are in danger of becoming aridly pedantic, mechanistic, and atomic. It is also easy to slip from using historical material into the habit of getting lost in it. Both errors constitute a misuse of psychoanalytic principles. These are the dangers against which the experientialist insistence on spontaneity in practice and humanism in philosophy may serve as warning signals.

On the other hand, counting on full emotional mutuality with patients as the major therapeutic lever means that other risks are run. Obviously, spontaneity derived from conscious intent is self-defeating. But a more subtle danger arises out of the easily blurred distinction between taking action and acting out, especially in neurotics. How "real" transference love and hatred seem, we all know. Acting out brings blessed relief from guilt and anxiety which easily passes for realistic freedom to feel and act. However, we know from work with impulsive characters that reliving infantile fantasies banishes anxiety so well that it greatly diminishes the victim's chances of resolving his basic conflicts. Neurosis may be perpetuated by the very "experience" which is supposed to eliminate it. Even though experientialists may not aim for permanent character change, they will want to avoid this trap.

If we examine the specific innovation of "touching"[1] which Dr. O'Hearne described and which is used as a means of breaking through defenses (resistance) and providing the patient with experiences which he has not been able to allow himself, two caveats come to mind. The analytic group therapist who takes a stand against it must beware of merely rationalizing his own possible fear of contact. Granting that being touched is a very moving experience for the patient and therefore a highly dynamic technique, it nevertheless poses certain dangers. The therapist may very easily be unaware of some profound and as yet untapped and well-hidden fantasies in the patient which could be stopped or reinforced. What may seem to the therapist to be a healthy exchange of positive feelings may arouse deep-seated fears or magic wishes. On one occasion, I experienced what I thought was great empathy for a patient's pain in reliving a period in which he felt rejected; I felt myself leaning toward him and realized I wanted to comfort him with a physical gesture. However, I asked—softly, so that my voice could convey my concern—what he was experiencing at the moment. He said, "I just had an awful feeling someone might gouge my eye out." His paranoid anxiety had not been exposed before so openly. Touching him at that moment might have been used as consensual validation of his fear, or, if enough rational ego was functioning, he might have repressed his rising paranoid fantasies. In Berne's terms, one must be sure that physical contact, like an interpretation, intended for the adult of the patient is not likely to be received and misperceived by the "child." The ecstatic feelings that can be aroused by a touch may mean to the patient that his infantile neurotic wishes will be fulfilled. Or his deepest narcissistic fantasy of perfect union with the other—that oceanic feeling —may be unwittingly reinforced. Since neither the therapist nor any other human being is capable of restoring the state of primary narcissism, disappointment is merely postponed. Meanwhile, the patient may be quite willing, as neurotics are, to continue to pay the price of neurotic anxiety, guilt, and suffering in order to keep his illusory hope. These are some of the pitfalls of touching.

To sum up, this Panel will, I hope, serve to remind analytic group therapists that "there can be a flight from the vividness of the world of

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[1] I do not refer to touching on such special occasions as when a patient's dear relative dies. Touching then falls into the category of what Greenson calls "the real relationship" and is not intended as a therapeutic technique.

instinct into the shadow world of words and concepts," and the experientialists that "there can also be a flight from reality in the opposite direction away from unpleasant knowledge into the dark twilight of vague intuition alien to intellect" (Fenichel, 1941). Both Scylla and Charybdis must be avoided in the complicated process of group psychotherapy.

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Working Through in Analytic Group Psychotherapy

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THE WORKING THROUGH PROCESS is the warp and woof of analytic therapy. Those of us who practice both individual and group analytic psychotherapy recognize that working through is as essential in the latter as it is in the former and requires the same laborious going over of detailed material, with repetition and elaboration of interpretations of defenses so that the defenses become less rigid and mechanical. The working through process, briefly defined, is the continuous attempt to transform intellectual insight into affective understanding by resolving those resistances (Greenson, 1965) which impede insight from leading to significant and lasting changes. Since affect makes insight more believable and therefore more subject to reality testing, it is, in short, what produces the therapeutic results.

How is the transition effected between intellectual insight and genuine change in feeling and action? Why is it so difficult to achieve even in the best regulated analytic treatment? This is so (Freud, 1914) because the three unconscious areas of the id, ego and superego involved in the reactions to the working through process are not only in resistance to this process but are in conflict with each other and within themselves.

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RESISTANCES OF ID, EGO and SUPEREGO

The Id

The id contributes to the working through process by projecting its archaic wishes in the transference and by striving continuously to accomplish them through the unconscious repetition compulsion; in bringing them to the surface, the id is involuntarily helpful in our efforts to analyze these infantile drives. The tenacity of the id in resisting change, however, creates great difficulties in therapy. Well known is the entrenched masochistic pattern of repetitive, passive, self-defeating behavior in patients. The individual analytic session was once considered the most effective arena for the production of regression, but experience over the past thirty or forty years with analytic psychotherapy groups has disclosed that the group milieu, by its special effects such as emotional contagion, splitting of the transference to the therapist, target multiplicity, peer identification, mutual support, and universalization (Slavson, 1950) is also effective in inducing regression,[1] and fears, guilt, and chronic infantile behavior patterns are revealed relatively early.

Although there is general agreement that there is regression in group psychotherapy, there is disagreement as to its depth. Scheidlinger (1968) points up the essential problem when he says, "Theoretically at least, the crucial issue in utilizing therapeutic regression in psychoanalytic treatment is not whether phenomena of the greatest 'depth' can be elicited, but, rather, the degree to which the observing, synthesizing, and controlling functions of the ego can be helped over layers of resistance to accept and to master them." The presence of fellow members makes therapeutic regression in analytic group psychotherapy different because of the quicker check with reality, but I question whether this difference is so basic. Although the repeated transference regressions with different members in the group make the episodes of regression shorter by the undeniable evidence to the patient that he is projecting similar distortions on dissimilar people in the group, this does not mean that the regression is necessarily less intense. The reliving of old hurts and traumas in the

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[1] Psychoanalytic ego psychology has expanded the definition of transference to include transference of defense as well as libidinal and aggressive drives, so regression as used here also means defensive regression. Durkin (1964) states that the defensive aspects of a patient's transference are the major targets of group analysis, a finding with which I agree. .

group can be extremely vivid even though the duration of such reliving may be briefer. It is as if the group patient receives short, irregular shocks instead of long, equally spaced ones.

The Superego

Superego resistance stems from unconscious feelings of guilt and the unconscious need for punishment and operates against the success and recovery of the patient in analysis, although at first the superego inadvertently helps the analysis by tormenting the patient to remember and confess repressed material. In the group, there is the added masochistic element of exhibiting one's self negatively to others. Later on the superego uses the working through process as proof that the patient is a hopeless case. Negative therapeutic reactions are evidence of the superego's misuse of dynamic interpretations for purposes of torture. Alexander (1929) noted this, and Bergler (1949) elaborated upon it. Alexander found that the superego was corruptible and could be bribed with pain and depression to accept disguised id wishes. Bergler showed that in a successful working through the superego does not become benign but changes its methods of torture. While the superego still remains cruel and antilibidinous, the aggression is now directed against the id and much less against the ego. The transformation of the superego from a corrupt to an incorrupt state is one of the decisive points in therapy, but constant work is required before the bribing and appeasing of the superego with pain, unhappiness, and depression can be brought to an end and the superego enabled to assume its "normal" punitive functions. If the therapist stresses this aspect of analysis and uses it in the group, he will find that group psychotherapy can be of inestimable value in the long, uphill job of working through of masochism, guilt, and depression. In the group, the other members often reinforce the therapist's interpretations of the patient's masochism. They point out his compulsive need to blame himself for what is unavoidable or not his responsibility. They show him also that if he makes a mistake or falls into a trap, he need not endlessly atone for it. The group can assume the functions of the incorruptible superego and not accept suffering and guilt as the price for the patient's unconscious enjoyment of his miseries. They can help the patient to say no and to avoid neurotic interacting or acting out so that he will not later have to repay the superego with depression.

The Ego

The resistances of the unconscious ego to the working through process are varied and subtle. The unconscious ego, having arranged a compromise between the id and superego at the price of symptoms, anxiety, and character problems, tries to preserve the neurotic balance and uses every means to defeat and offset any affective interpretations. Learning something new, especially something painful, upsets the basic narcissism of patients and they react with anger. It also revives their fear of passivity, with its unconscious meaning of being pushed into a passive position and overwhelmed or wiped out. The patient is in conflict between the pleasure and reality principles. Removing the resistance of the unconscious ego enables the patient to accept the limitations of reality. The infantile ego wants to cling to the fantasy of megalomania and, resenting any imposition of reality by effective interpretations, it defends rigorously against them. The long, tiresome and repetitious task of working through further infuriates the unconscious ego, which reacts with anger, boredom, and pessimism.

In several papers (Glatzer, 1959, 1965, 1967) on group treatment of orally regressed characters, I have shown that interpretation to fellow group members of similar chronic character problems lessons the narcissistic hurt for these patients. It is also less anxiety-producing for them to accept such interpretations from peers who are not as invested with the archaic witch fantasy, especially for those patients who have an inordinate amount of unconscious fear and hatred of the pre-oedipal mother. But there is another kind of group interaction which has come to my attention, that of repairing the narcissistic wound sustained by having had to accept an interpretation by the therapist in individual treatment. In order to obliterate the insult, the patient represses the interpretation and then uses it on another member as if it were his original discovery. When this is called to the patient's attention in the proper setting, it becomes subject to reality testing and helps to promote genuine insight. The following is an illustration of this.

Among her other problems, Gloria, an intellectual college graduate, had enormous difficulty in reading. This created great tension on her job, and it was only her phenomenal memory that carried her through. In individual treatment we had connected this reading inhibition with her early guilt about using reading as a way of indulging in incestuous

fantasies. Not being able to read easily was a reaction formation against the wish to peep and the price she paid her superego for her childhood voyeurism. We had also related her inhibition to her rebellion against her mother's urging to read and be intelligent. Her resentments of her mother were numerous, but one of the principal hurts was her mother's preference for her brother. These interpretations, which were partially understood and accepted, helped to improve her relationship with her mother but did not substantially lessen her reading block. At one group session, when another member talked about his difficulties in studying and reading, Gloria began to question him. She eventually made the "electrifying discovery," first for him and then for herself, of the link between the reading block and the voyeuristic inhibition and the rebellion against the mother. She could accept these interpretations only when her narcissism was placated, only when she believed she had actively discovered these interpretations for herself and did not feel pushed into the passive position and thus rendered vulnerable to the power of the dreaded pre-oedipal mother. She could also repair any narcissistic injury by identifying with the powerful mother and actively giving to another member (younger brother). At a later session, when another group patient also made a "new" discovery, the group reminded him that they had heard it before. I called to their attention this general unwillingness to give the therapist credit and explained it as a defense against fear of passivity, applying its particular application to each of them.

A survey of all analytic therapies indicates that all too often results fail to meet expectations, especially with severe psychoneurotic, borderline, and character disorder patients. Analysts have found that the ideal aspect of working through does not materialize, no matter how well conducted the analysis. Brodsky (1967), in a recent article on working through, discusses this problem. Although he agrees that transforming insight into affective experience leads to changes in character and behavior, he feels that the aspect of this that is central to working through is the mastery of painful affects, particularly anxiety, and refers to Waelder's description of working through as suffering through. In my examples, I hope to show the dynamic quality of reliving painful affects as it takes place in the "here and now" group setting, where multiple cross-transferences, identifications, and defenses are enacted in an elaborate network that produces striking insight. Karush (1967), in a recent paper, writes that an impediment to working through is often introduced by the analyst's countertransference, which is compounded by the theoretical concepts of proper passive techniques. He advocates that the analyst be more active as a teacher and an idealized object who influences

by example. In another paper (Glatzer, 1962), I have described how the role of group analyst makes him more flexible, active, and responsive than the individual analyst, and how together with other group members he can more easily convey reality. The greater activity of the group therapist makes him a more available object for constructive identification, and he can ultimately become the representative of the stronger ego and less corruptible superego.

The feeling of impatience on the part of the analyst which is almost inevitably associated with the working through process is intensified when working with orally regressed, long-suffering, masochistic patients. The therapist often becomes involved in countertransference with these difficult patients and may respond with anger, boredom, pessimism, or passive masochism himself. In the group, transferences to peers provide the patient with opportunities to break up the transference neurosis impasse with the analyst. The other group members often take over for the analyst and insist that the patient face his transference distortions, thus giving the therapist enough of a respite to regain his objectivity. Kubie (1968) has stated his pessimistic opinion that resolution of the transference phenomenon is limited even under the best of conditions and urges that it is essential to explore the effect of introducing extra analytic contacts between patient and analyst and/or changing therapists. In an almost apologetic way, he also suggests that the therapist consider placing the patient in group analysis toward the end of an analysis.

As Fried noted (1961), there is greater productivity and action in analytic group therapy than in individual treatment because the patient is likely to express his feelings directly in reactions and actions rather than just reporting them. We who have been doing combined individual and group analysis know the tremendous impetus group therapy gives to an analysis and how much it contributes to resolution of the transference neurosis. Even the most passive patients can resolve their sticky dependence on the analyst and are able eventually to give up individual and later group therapy and be on their own. The summation effect of other members' observations, the repeated evidence of the distortions in the interconnecting transferences, and the continuous exposure of the defensive structures reinforce reality for the patient and help him to break through to affective and lasting understanding. This does not mean that the working through process in group psychotherapy is not long, laborious, and tedious, and sometimes it is particularly unwieldy

because of the greater opportunities for acting out. But the splitting of the transference to the therapist and the projections on to others in the group make it more bearable for the analyst.

CLINICAL ILLUSTRATIONS

In individual analysis, Andy, a young lawyer, had made many gains, but his rivalry with his peers suggested that group therapy might be of benefit. His keen competition with others undermined his strong potential in his profession and seriously affected his social life. He was also still locked in a symbiotic relationship with his wife, with whom he acted out the part of the deprived child of a niggardly mother. His wife was baffled by his strong dependency needs, his infantile rages and hypochondriacal worries. Although their relationship had improved so that they were no longer contemplating divorce, there was still a large residue of neurotic acting out between them. (She was in treatment too.)

When Andy entered the group, he expected to be not only the therapist's favorite but the group's. His years of analysis, his intelligence, good looks, and appealing ways made him anticipate an easy victory. To his dismay, he found himself with a group who saw readily through his defenses and began to resist his attempts at a "snow" job. This had the effect of making Andy try harder to be more charming, sincere, and concerned about everyone, but he only succeeded in exposing this brittle defense.

Andy's rivalry in the group centered on Richard whom he envied and wished to show up. This negative transference was reinforced by the fact that Richard came from the right side of the tracks and possessed all the social and intellectual attainments which Andy felt were his prerogatives. Richard was well liked and admired in the group because he had moved a long way from his former schizoid detachment and caustic provocations, and the group members appreciated the witticisms and good will he was now able to express. Having the group prefer Richard to him repeated earlier traumatic experiences in which Andy had felt that his father, and later his stepfather, had taken his mother's attention away from him. In his youth he had worked at undoing this by trying to get friends to love him and win them away from the favorite. When he could not, he would go to his mother for consolation. He repeated this in the group and again became the little pygmy who

tried to fight the big giants by being smarter and more endearing. His constant efforts to turn the group and the therapist from Richard only resulted in exposing his blandishments and pushing Richard into the role of the "wise" elder who either ignored Andy or explained him.

Simultaneously, Richard, on his part, was unknowingly working through with Andy his relationship with his dead younger brother who had been "better looking," more social, preferred by their mother, and sought after by the girls. This transference to Andy was not clear until the day Andy brought in a dream in which his mother, father, and grandmother (who had adored him) were alive. Associations revealed that Andy's dream was a defense against the group's insistence the week before that Andy face up to his mother's death and stop reliving the fantasy that she was still alive and a bulwark against his dying. The group was also united in their insistence that he give up playing the role of the charming little boy and be himself. The group now became the incorruptible superego who would not let him get away with exhibiting himself masochistically. The superego was still exacting and antilibidinous but in a more constructive direction. He was being forced to grow up and face the unpleasant task of relating and dealing directly with people.

Richard's unconscious jealousy of Andy was touched off when the group devoted a great deal of time to Andy's dream and connected his fear of death with his rage against the omnipotent mother who abandoned him to mortality by dying herself. This jealousy of Andy plus the death theme reactivated Richard's anxiety, which he expressed in two brief dreams. In the first, he heard that his cousin, mother, and sister were dead. In the second, he had to complete his unfinished fourth year at a state university, (not the Ivy League college from which he had graduated). It was a breeze for him, but when he had to give a talk on De Soto in front of an audience, he found he had not prepared it and woke up in a panic with perspiration rolling down his face. Richard's associations indicated that the cousin was his brother and that the previous week's discussion about Andy's fear of dying had revived his anxiety about his brother's death. A woman member suggested that Richard's going like a breeze through his fourth year at the state university represented his fourth year in the group, where he had earned a position of respect and admiration for his therapeutic changes. Another member observed that there might be a connection between Richard's brother and Andy. Some of the more recent members in the group had

not heard details about the brother's death and asked about them. They were told by Richard that his brother was killed while asleep in his girl friend's De Soto convertible which she was driving. Richard stopped and gasped, "Oh, my God, the talk on De Soto and the De Soto car. I never recalled the make before. I had completely forgotten it." Chuck, another member, said with deep emotion that Richard's fear of women as killers was strengthened by his brother's death and that he connected falling asleep, orgasm, and being killed. This was one of Chuck's anxieties too. Although it had been gone over many times in Richard's individual treatment that he felt guilty for his brother's death and that he experienced women as killers, these two ideas had never been linked together. Through the unique by-ways of the group process—the discussion of anxiety-producing topics, such as fear of dying and omnipotent mothers, as well as the reliving of intense rivalry feelings plus the spontaneous reactions, involvements, and interpretations by group members—there was enough of an impact in all of this to produce the dreams which revealed Richard's still unresolved guilt for unconsciously wishing and accomplishing the death of his popular brother by the dreaded all-powerful female and the great anxiety that he would be punished for this by being killed himself by her. The basic superego accusations were finally exposed, and we could begin to grapple with the heretofore almost inaccessible core of repressed fear and guilt.

Introduction of new members to a group that is functioning well often brings out a large variety of reactions and deepens transferences, as I have discussed in another paper (Glatzer, 1965). When one of the new members becomes a convenient scapegoat by virtue of his exasperating characteristics, there can be such an intensification of the working through process in other members that the gap between emotional insight and action is bridged. This holds true even in frozen character resistances, as the following examples illustrate.

Evelyn, who had previously been in a long analysis elsewhere, had been in combined treatment with me for a few years. Much work had been done on her oedipal attachment to her volatile and irascible father, and a modus vivendi had been established between them, but she was still unable to relate well to men. In her individual treatment with me, we had worked on her archaic fear of her mother so that she could now permit herself to succeed in her work (she had unconsciously feared her dead mother's retaliation if she were successful; she also felt guilty

about achieving because of her unconscious death wishes and because she felt she had not taken care of her mother during the latter's long illness). Evelyn was apprehensive when she first entered the group, and it took a long time for her to thaw out and interact with the others. Although she now felt more comfortable with the group and was better able to show her feelings, she was not as communicative as she should have been and there was still a barrier between her and the group, as indeed there was between her and the outside world.

In this same group was Clarisse, whose passive father had sided with her psychotic mother no matter how irrationally or cruelly she had behaved to Clarisse. Clarisse had retreated to books and fantasy as a child, and it was only through a long childhood analysis that her high intellectual abilities were freed enough and her emotional conflicts lessened sufficiently so that she could start a career and make a good marriage. Her former analyst referred her to group therapy with the hope that it would help her relate better to women and to improve her marriage. In individual therapy, she had not been able to work on her negative transference to her analyst, who had literally acted as a bulwark against a complete retreat and to whom Clarisse could only feel gratitude and love.

Clarisse knew intellectually that she was often irrationally furious at her husband and used him as her witch mother, but she could not stop herself from repeatedly getting into fights with him, and the marriage was exceedingly stormy. She would come to group sessions feeling either victimized by and furious with her husband or guilty and depressed, saying that she was to blame and would beg the group to help her. Clarisse's use of her husband to re-enact her relationship to her psychotic mother was gone into many times, and there was some improvement. The group became the incorruptible superego who picked up Clarisse's underlying excitement at being badly treated and kept showing her how she could avoid interacting with her husband. She would straighten out the discussed situation, but the resistance was still too strong and she would come in with a different version. The compulsive need to repeat new editions of old marital woes had begun to pall on the group, and they became irritated with her for not acting on her "perfectly good insight," for not resisting the multiple opportunities her husband gave her to fall into their sadomasochistic trap. And to Clarisse the group had become her bad father who did not appreciate all her intellectual efforts.

She "understood" this too but remained hurt and angry by what she felt was the group's unwillingness to understand and help her.

In the fall of the year two new members joined the group. Emanuel was a man whose neurosis expressed itself in unclear speech and provocative behavior. He alternated between showing his resistance by speaking in an almost cryptic style, turning everything into a banal joke, or by flying into rages at various members when they did not agree with him or when they pointed out his resistance. At one session, after Emanuel had unconsciously provoked the group with his political views, he started shouting at them for looking down at him and accused them of not liking him for snobbish reasons. Clarisse reacted with rage to his outburst, and she accused me of making a terrible goof for bringing him into the group, saying that he was in the elementary stages of therapy and completely on the wrong wave length and the group was wasting time trying to explain fundamentals to him. She wept as she said that I had ruined the group and she was going to leave. This was the first important breakthrough of her underlying hostility to me.

With Emanuel and Clarisse yelling at each other, Evelyn clapped her hands to her ears and shouted, "Stop him from screaming! I can't stand it, I can't stand it!" Everyone, including Emanuel, stopped talking. Her outburst had a profound effect on him and made him realize how he frightened and antagonized other people. Evelyn sobbed that she agreed with Clarisse that I had ruined the group by bringing in Emanuel, and she too was going to leave.

In the working out of this episode, what came out was this. To Clarisse I was her weak, unloving father who preferred her psychotic mother and let her overwhelm Clarisse. To Evelyn I was the weak, unloving mother who let her shouting father dominate the household. Here was a dynamic reliving of basic narcissistic traumas, with both patients witnessing that I was the opposite parent to each, as was Emanuel. The transference distortions became so apparent that they could readily see them and they calmed down. Here was a quick check with reality as they experienced the same thing in different ways and could see it operate in each other. It was interesting to see how friendly and helpful these women became to Emanuel later on. I think the affection and patient understanding they gave him subsequently came from the fact that they unconsciously appreciated that it was through him that they had come face to face with their deeply repressed, archaic

hatreds. He, in turn, responded to their changed attitudes and stopped making so many frivolous and irrelevant remarks and began to reveal his inner conflicts. A year later, a man who had had to leave the group for about five months expressed surprise on his return at how much clearer Emanuel's speech had become.

Further illustrating the complex reverberations of an intense event in a group was another member's reaction to this same flare-up of Emanuel's. At that time Bryce seemed to be Emanuel's only friend in the group and his apologist. At the following group session after the outburst Emanuel was late, and the group wondered whether he would return and whether he should be asked to leave if he did come. Bryce was forced to face his strong ambivalence toward Emanuel, and when Emanuel arrived there was a showdown. In the talking out of his feelings about Emanuel, Bryce realized that Emanuel was both the loved, admired and hated rich uncle who had been the shining model for his mother. His mother had raised Bryce to become an educated man like the uncle and had starved herself to send him to college. Just before the group met, Bryce had bought an antique bracelet for his wife and had shown it to the women members in the waiting room. One of the women reminded him of this, and in a startle reaction he recognized that the bracelet he had bought was like one his uncle had given his mother and that I looked like his mother. In an examination of this, his hostility to his mother came out for depriving herself so excessively that he seemed unable to free himself from guilt and the immoderate responsibilities his superego demanded of him. Bryce could now recognize that he too had been furious with me for bringing in Emanuel and, through Emanuel, forcing him to face his deeply repressed ambivalence toward his uncle and mother.

Jonathan, the other new member who came into the group at the same time as Emanuel, was also naïve psychologically, but he was so likeable that everyone tried patiently to help him with his problems. Jonathan suffered from acute sexual anxieties and conflicts. He had been hinting about them for a number of meetings, and at this session he had started to confess his sexual fantasies with much anguish and embarrassment. He had the undivided and sympathetic attention of the entire group. He was groping with his thoughts, and in their efforts to help him overcome his discomfort, the group kept interrupting him. He broke out in a sweat and appeared so anxious that I told the group to hold up

their reactions until he had finished. Evelyn had been talking at that moment, and I could see her become pale with fury and withdraw into her former icy remoteness. When Jonathan finished and the members had given their suggestions and impressions, I picked up Evelyn's anger with me. She denied it, but she remained aloof for months and months. She retreated into her early, non-interactive phase, and her face displayed pallor and a faraway gaze. None of my interpretations nor the group's urgings made any impact. It was only months later, after she had made a particularly caustic reply to one of my interventions, that Clarisse and Fern, another member, turned on her with anger at her stubbornness. They said they resented her lambasting me and felt she had exaggerated what I had done and were hurt at her withdrawal from them. The emotional confrontation by her two women peers apparently burst the floodgates, and Evelyn permitted her injured feelings to come through.

The Jonathan episode had been a re-enactment of when she was a small child, witnessing all the attention her mother paid to her father; when she would express her jealousy of him, her mother would send her out of the room for being an impertinent brat. The group made her face reality and showed her that I was not the restrictive mother who preferred father (Jonathan) and sent her away but that I had interrupted everyone and had not stopped just her. They pointed out to Evelyn that by retreating from the group she had achieved the feeling of being sent away and that she had done it to herself. Although she had been aware of this all during the time she had been in her withdrawn state in the group, she could not break out of it herself; she needed the emotional confrontation and real concern from the group to translate it into genuine insight. She confessed now that she had had an additional grievance against the group. Douglas, another member of the group, had taken on the role of good father figure for all. He had shown his preference for Fern, and at one group session Fern and he had revealed their sexual and tender fantasies about each other. Evelyn, who had repressed her hurt and jealousy, now understood that her recent dislike of Fern was because Fern had become her younger sister whom she felt her father preferred. As she talked about this, her eyes began to sparkle, she lost her pallor, and she began to come out of her three-month trance.

Strong transferences between members often evoke profound reactions in other members. For example, Clarisse telephoned me shortly after the ventilation of the sexual-love fantasy between Douglas and Fern

and said that she wanted to leave the group because she felt it was no longer useful to her. I suggested that we talk this out, and during the individual interview I interpreted her jealousy of Fern, whom she had described as coy and insincere. I could see that she was rather frightened of her jealous rage at Fern and I helped her to look at it. She could accept this from me because she had faced her hostility toward me for bringing in Emanuel. At the next group session she tearfully told all this to Fern and the group and was emotionally relieved at Fern's acceptance of her anger and jealousy. This was the first time she had been able to look directly at her feelings of hostility and jealousy toward another woman in the group. The feelings could come out only after she had expressed her archaic hate and distrust of mother through me. Having worked on this with me and then with Fern, she began really to understand her rage with her mother and she no longer had the same compulsive need to use her husband as the witch. Her previous intellectual insight had only served to make her feel more guilty, so she had had to provoke her husband into anger and then had to grovel masochistically before him to allay her superego reproaches. This only maintained the sadomasochistic interplay between them. When she really understood, she avoided the traps that her husband set for her and that she set for herself, and there was a marked and lasting improvement in their relationship.

SUMMARY

Analytic group psychotherapy helps the working through process by accelerating regression so there is quicker access to unconscious conflicts. It also helps by reinforcing the analyst's work with superego and unconscious ego resistances. Superego resistance is considered by the writer to be a major block to therapeutic progress. Transformation of the superego from a corrupt to an incorrupt state is one of the decisive points in psychotherapy. This, in turn, strengthens the ego. Other members in the group often help with this task and become reinforcers of the incorruptible superego. Examples have been given to show the variety of ways in which the narcissistic anxiety caused by effective interpretations from the analyst is lessened in the group. When unconscious resistances are manifested in the elaborate network of transferences and analyzed in the dynamic here-and-now, the repeated evidence of transference distortions

adds emotional impact. There is an eventual mastery of painful affects and a dynamic restructuring, sometimes even with chronically frozen character problems. Last but not least is the help the other members afford the analyst when a particularly stubborn and masochistic patient involves the analyst in a transference-countertransference problem.

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Issues in the Training of Group Psychotherapists

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Probably the most significant factor in the shaping of group therapists is that most formal programs for training group therapists emerged from and are still conducted in institutions where the primary emphasis is on individual therapy. Even when an institute has been established exclusively for the purpose of training group therapists, the supervising personnel are likely to have been trained in the former type. Although exceptions exist, the tendency is for most training programs to rely heavily, if not exclusively, on individual supervision as a training device, with the trainee assuming the role of apprentice.

In recent years, the use of groups for therapeutic purposes has both diversified and proliferated. More persons in the mental health and related professions are conducting groups; diverse patient populations are becoming increasingly involved; and group activities, while not therapy in the traditional sense but with therapeutic purpose, are increasing; yet training has not been appreciably altered to meet these changes. These developments suggest that some rethinking about the character of appropriate training for those who intend to use groups to help people would be in order.

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In undertaking this rethinking, we think it inappropriate to prescribe a specific training program. Indeed, considering the diversity referred to above, no single program of training could be expected to meet the needs of all trainees. The trainees start from different professional backgrounds and bring with them different skills and background knowledge. They are likely to apply their training to quite different patient populations in different settings.

While eschewing prescription, it has seemed to us useful to bring forward for consideration a series of training issues likely to be present for any would-be group therapist, and consequently necessary for any training program to take into account. Our procedure in this paper, therefore, will be to discuss a series of general training needs and to consider a number of both traditional and innovative training procedures in the light of their potential contribution to these needs.

Any therapist who undertakes this task is bound to produce a list of needs and issues which reflects his own views about the nature and conduct of group therapy; therefore, let us be explicit about our views. Our position is that the therapy group creates its own unique social system with properties distinct from those to be found in individual therapy (Lieberman, et al., 1969) and that the practice of group therapy should take into account the ways in which these unique group properties channel change processes within the individual. Ideally, the therapist should be alert not only to the needs, conflicts, and defenses of each individual patient, but also to these individual dynamics as they are expressed in and influenced by the milieu of the group. One of the important roles which the group therapist must fill—which has no counterpart in individual psychotherapy—is that of the "social engineer." By this term we mean that the therapist must be alert to group forces and must monitor and attempt to influence these forces so as to generate a constructive and therapeutically beneficial milieu for his patients.

We assume that the over-all goal of a group therapy training program is to familiarize the trainee with the character of the group as a therapeutic milieu and to train him to understand the experience of the patient who comes to it. Also, the program must provide appropriately guided opportunities for each trainee to test himself in the role of group therapist so that he can decide whether to develop a personal investment in doing this form of therapy and how, if he decides affirmatively, to become effective in its practice.

PART I. TRAINING NEEDS

1. *The trainee needs to make explicit his own implicit help-giving model and generate a model appropriate to the group situation.* No one who reaches a point in experience at which he enters a professional training program can have failed to establish his own personal view of what a helper is like and how he behaves, and what a helpee is like and how he behaves. The image of the helper is likely to be related in some way to ideas of the helper as teacher, parent, doctor, or to an image of how a therapist or analyst would behave. Similarly, the image of the person who is helped may have been shaped by experiences as a child, medical patient, student, etc. Some model of this relationship doubtless exists for every trainee. Perhaps the model is an amalgam of earlier experiences, or possibly even incorporates a reaction against some of them, but it is certain to bear some relationship to personal experiences of helping and being helped. Most likely, the helping model is largely implicit. Often, it involves some definite ideas about how much of an expert, social equal, authority, intimate, and social model, and how emotionally expressive, the therapist ought to be.

This issue of the trainee's help-giving model is particularly important because the model we visualize as most appropriate to the group is not likely to be generated by the typical trainee's personal or professional experiences. Specifically, the model we suggest as most appropriate for group therapist training focuses on the management of social forces and the utilization of group resources. These foci are not characteristic of the traditions from which most therapists stem. The therapeutic model which is shared by the helping professions is usually a medical model in which the patient is sick and in need of something to be done for him. An alternative in recent years has been a "hothouse model" in which psychotherapy fosters a relationship which serves as an artificial climate designed to promote growth. A third model may be only half facetiously called a "powerhouse" model; it is one in which positive persuasion is used to deal with the problems the patient presents. All three of these models emphasize the therapist's role as unique savior or authoritative expert, and their respective emphases do not take into account those natural processes occurring in groups which are most potent for change. Thus, it seems to us that any group training program must look care-

fully at the assumptions it has or that the student brings with him about the help-giving process and the role of the helper.

2. *The trainee needs to understand the unique character of the group as a medium for therapy.* Certain phenomena which one finds in groups can occur when a number of persons meet together in a face-to-face situation. Others, though not present in all small groups, are likely to emerge in a therapy group because of the special stress placed upon the individual in his role as a patient. Specifically *group* phenomena include the following:

a) The group's capacity to define reality through consensus. Unanimous opinions on the part of the patients—about the therapist, each patient, what is right and proper, etc.—tend to be felt by each person as real, convincing, and compelling. The therapist needs to be aware of the power of a group consensus so that he can cope with his own feelings should he become the object of the group's unanimous scorn, admiration, or curiosity, and so that he can monitor the situation when some antitherapeutic or erroneous view of reality is being lent credence by unanimity.

b) The group's capacity to establish standards for behavior and to try to impose them on its members. Here, the need on the part of the therapist is to understand the necessity for shared standards in the group, the various attempts patients will make to impose these on reluctant members, and the conditions under which such pressured individuals are and are not likely to conform. Again, the need is for the therapist to monitor the standards which emerge, permitting or encouraging those which he regards as furthering the therapeutic process and interfering with or challenging those which he regards as antitherapeutic.

c) The group's capacity to cast various of its members in particular roles. Sometimes a group and a particular member will collude together to place that member in the position of an isolate, a destructive person, a spoiled child, or even an expert, and sometimes the position which a person thus comes to occupy restricts the therapeutic movement which could otherwise occur. Alternative behaviors may not even be considered. The therapist needs to be alert to such possibilities so that he can avoid unwitting collusion with such a patient and the group in fixing him into nontherapeutic positions.

d) The group's capacity to offer its members warmth and a sense of belongingness. This capacity has both positive and negative potential

effects. For the patient who feels isolated, alienated, or unacceptable, the group's capacity to offer warmth and belongingness may provide a way back into the human race. However, the patient who comes to value this above all else may reduce his risk-taking to a point where therapeutic gain ceases to occur. The therapist needs to recognize the quality of the cohesiveness present in the group and its meaning for each of the patients.

e) The opportunity for direct interaction with peers. Unlike individual therapy, the group offers opportunities to practice new behaviors within the boundaries of the therapeutic situation itself, with peers. That is, a patient may try out more direct ways of expressing anger or warmth, or he may confess to traits which he has hitherto considered unacceptable or reveal past experiences of which he has been ashamed. In each instance, he will have the opportunity to see and experience for himself the reactions of others who, like himself, are not bound by the conventions of the therapist's role. This can constitute a constructive form of reality testing. Sometimes, the special relationships which spring up among patients, or the trying out of new behavior, have been regarded as "acting out within the group." This can indeed occur if the group provides merely an opportunity for the discharge of feelings. The therapist must learn to sense the distinction between useful reality testing within the group and "acting out," which prolongs and reinforces neurotic patterns, and to develop skill in helping patients turn the latter into the former.

f) The patients' capacity to collude in erecting defenses. When confronted by a threat which is experienced in common, the patients in a group are capable of collaborating, usually without being at all aware that they are doing so, in erecting shared defenses. They may, for example, keep a trivial conversation going as a way of avoiding their real concern; they may scapegoat one of their members; they may maintain a stubborn silence; they may psychologically wall off or exclude a difficult patient. Such defenses can be powerful and intractable. It is necessary for the therapist first of all to be able to recognize when such processes are occurring, then to sense when to intervene and when not, and finally to know how to intervene with some prospect of success.

g) Fears of revealing vs. fears of concealing the shared hopes and fears of the patients. The patients are likely to see the therapy group as a potential source of help. Their hopes are placed in the group and in the group therapist. They are also likely to assume, or they soon learn to

believe, that in order to be helped they must talk about their feelings and problems. This tends to generate fears of the consequences of such frankness: fears of being ridiculed, condemned, or rejected. Such fears can be massive and primitive, especially during the early phases of the group, and they lead to the erection of various individual and group defenses. The group therapist needs to understand the profound character of such fears so that he does not become too impatient or press too hard and so that he recognizes and nurtures the early signs of mutual trust and confidence as they emerge in the group.

3. *The trainee needs to understand the relationship between dyadic and group therapy.* This is particularly important because many potential group therapists learn in the first instance to become therapists by dealing with one patient at a time in individual therapy. There is some tendency, then, for them to transfer the attitudes and skills learned in the two-person setting to the group without critically examining their relevance and limitations. It is helpful, therefore, to identify and make explicit the relationship between the two forms of therapy, identifying those attitudes and behaviors appropriate to both settings and those which may be appropriate to the one and not to the other. Examples of attitudes and behaviors appropriate to both settings include attitudes of respect toward the patient, honesty in one's expressions, and understanding of the dynamics of individual personality. Other therapist attitudes and behaviors require revision in the group setting. For example, the group therapist must learn to attend to the interactions of pairs, subgroups, and the group as a whole, rather than focusing on his own relationship with each patient; he must adopt a different position vis-à-vis power, centrality, reality-defining function, etc.; he must enlarge his repertory of therapeutic and managerial tactics in order to exploit the group situation positively.

4. *The trainee needs to become empathically aware of how the patient feels.* The patient is in some sense a "target" in the therapeutic group. Patient colloquialisms—"being on the hot seat," "on the griddle," "it's your turn today"—frequently express experiences that are not always felt to be supportive or reassuring. Group treatment *means* the utilization of group forces developed when a collection of patients meets as a unit over time, and these forces are bound to exert occasional pressures toward conformity, to exercise regressive influences, and even to develop scapegoating as a technique of dealing with collective anger,

guilt, etc. The power of these forces is not unidirectional; they do not always operate in the most helpful way. Particularly if the trainee is unaware of the operation of these forces, he is unlikely to be able to ensure their constructive use. He may even unconsciously or inadvertently facilitate their expression in a way that hurts rather than helps. We feel that it is operationally important and ethically imperative that training enhance to the degree possible the trainee's awareness of how the patient feels in the group. How does the patient feel when he takes certain role positions—when he is the most active or the most passive, when he initiates the discussion, when he reveals painfully intimate details of his most personal relationships? How does the patient feel when under attack by several other members simultaneously, when his veracity, sincerity, or even his intelligence are questioned? The trainee should know what the individual experiences when he occupies the position of scapegoat or isolate, or when group anger is directed his way. There are moments when the entire group seems to demand revelations that the patient is unprepared to make or when approval is expected which the patient does not wish to give. Particularly panicky feelings assault the patient when he feels alone, cornered, or deserted—even by the therapist. Waves of despair move through a group when one of its members reports a personal failure or when several share their feelings of hopelessness.

If the therapist can empathize with the patient's feelings under the conditions we have described—all of which occur at one time or another in a group's history—he is less likely to be thoughtless or unwittingly cruel in his own activity, and less impatient or contemptuous of his patient's defenses. Without the ability to assume the role of the patient in a group, the trainee's potentiality for irresponsible behavior is no less than that of any of his patients; with it he will be able to help his patient experience the group forces as aids. In his empathic responsiveness to his patients, he may model for them an ideal of ethical interpersonal responsibility which is a key factor in healthy relating.

In many ways, achieving and sustaining empathy with the individual in a group is more difficult than in a dyad. The reason is, of course, because of the multiplicity of empathic demands being expressed. For any therapist there is a tendency to collapse the "I-thou" of the dyad to the "I-it" of collective experience (a factor which steers some patients and therapists away from encounters with groups). Overcoming this tendency requires an extra effort in the face of the group forces which influence

the therapist much as they do the patient. Constant monitoring of the individual-in-the group is difficult but imperative for the group therapy trainee.

5. *The trainee needs to become aware of and resolve or control his fears of the group.* In consequence of the special features of the group, the group therapist is likely to be particularly vulnerable to certain kinds of fears and apprehensions. For example, a group of patients may develop a shared belief or consensus about the therapist which the therapist cannot accept or finds threatening. They may decide that he is incompetent, inexperienced, not interested in the group, etc. Because consensus lends credence to such beliefs, the therapist feels their impact strongly (most emphatically of course, if the group's opinion coincides with covert fears of his own). To take another example, the therapist, sensing the sometimes powerful character of the group affect, may fear that strong emotions will erupt which he will not be able to control, or, because of the capacity of the group to collaborate to establish shared defenses, he may fear the erection of implacable group defenses against himself. He may be disturbed or dismayed to find that he is not the sole source of therapeutic help in the group, indeed that on many occasions the group seems to do very well without him. In consequence, he may feel robbed of his appropriate role. It will doubtless disturb him to find that episodes occur in the group which he does not understand and which have him at a loss to know how to be helpful. Many therapists, even experienced ones, find it difficult to be the target of unanimous hostility, multiple demands for help, and the like. Not all therapists are vulnerable in the same way or to the same degree, of course, but it is hard to imagine a therapist who is wholly untouched by these concerns. If a therapist operates out of fear, without realizing it, he will make errors. If he recognizes his fears, he is more likely to control the behaviors which would otherwise be generated solely by the fears.

6. *The trainee must have an understanding of how persons are helped in a group.* Lacking such understanding, the therapist proceeds on an ad hoc basis and is likely to miss critical opportunities to make helpful interventions. He may even work destructively, against the therapeutic process, without realizing it. Two kinds of faulty models are typically utilized by inexperienced persons. One is that the trainee transfers to the group whatever model he has found useful for understanding the events of individual therapy, a model that is usually inadequate, for

it focuses on dyadic relationships and fails to take into account the specific dynamics of the group. The other is an uncritical acceptance of a kind of "mystique-of-the-group," which assumes that, in some unspecified way, merely being in a group will generate therapeutic benefit to all the members.

Although a comprehensive and satisfactory model of group therapy which takes specifically group phenomena into account does not yet exist, a number of theories about therapy in groups provide some basis for thinking about the behavior specific to them. We have in mind the ideas of Bion (1959), Foulkes and Anthony (1957), and Whitaker and Lieberman (1964). If the trainee is exposed to these, he can test for himself how and to what degree they illuminate what happens in his groups, and the kinds of interventions and activities on the part of the therapist they suggest.

7. *The trainee must learn to operate as a therapist.* The ultimate goal of training is to produce a therapist who can grasp what is going on in the therapy group, have some feeling for the internal experience of each patient, and behave in a way which will help both the group as a whole and every patient in it to move in a constructive and therapeutically beneficial way. Training should, moreover, develop skills to do this right on the spot in the immediate situation, while the interaction is going on.

8. *The trainee needs to become aware of his own natural preferences, embedded in his own personality, for a therapeutic role.* To this point we have been concerned with the social roles of helper and helpee (tinged as these must be with idiosyncratic personality characteristics), now we wish to make explicit the question of each trainee's personal therapeutic style. It should not be surprising that the group therapist, no less than the group patient, will try to develop for himself a role or position in the group which he finds comfortable and rewarding. For the therapist, this means that he may feel most comfortable when he is more—or less— central, powerful, intimate, distant, open, secretive, self-effacing, and expressive. A therapist may operate selectively to screen out or to encourage certain kinds of behaviors or discussions. One thinks of the therapist who always turns off hostility as being "too dangerous for the patients," of the therapist who distances himself by restricting his participation to one long and complex comment at the end of each session, of the trainee who insists on being called by his first name in order to

"reduce the humiliation of being a patient." It is obviously desirable for the trainee to become aware of his personal preferences for what they are, so that he may avoid elevating them to the dignity of being justified by theory. Hopefully, personal needs which lead a trainee to establish a role for himself which works against the therapeutic process can be recognized and modified or controlled. Occasionally, a trainee may be fixed in a personal style which is inappropriate to a group, although he might be an adequate helper in other therapy forms. If this is recognized and its implications faced, it may lead the trainee to pass up the role of group therapist in favor of one which is more congenial to him.

PART II. TRAINING PROCEDURES

If this list of issues indicates a series of training needs, how are these needs to be met? Some commonly and not so commonly employed training procedures include (1) didactic teaching, in which the trainee listens to lectures or reads books; (2) participant learning, in which the trainee is placed in the position of patient or group member; (3) vicarious exposure to groups through tapes, films, transcripts, or the observation of live groups; (4) role-playing and exercises; (5) apprenticeship learning, in which the trainee is a co-therapist or therapist under supervision; and (6) seminars and discussion groups. We shall take each of these in turn, discussing their relevance to the training needs and some of the considerations and problems involved in their utilization.

1. *Didactic teaching, in which the trainee listens to lectures or reads books.* Didactic teaching tends to be de-emphasized in training programs, perhaps because of the recognition that conducting a therapy group is a skill and that a skill is something which must be learned through practice and not primarily through reading. Still, there is a place for this kind of learning in a training program. No doubt, the most economical way of being exposed to a set of ideas about a subject is to read about them in books or articles or hear about them in a lecture. Two of the training needs mentioned earlier can be partially fulfilled in this way: the need for some model of how persons are helped in groups, and the need to understand the unique character of the group as a medium for therapy.

If didactic teaching is to be included in a training program, three questions arise concerning its use. The first of these has to do with selection of articles, books, or topics. Is a single, internally consistent

approach to group therapy to be presented? Does the instruction present a limited number of conceptual approaches, different but compatible in outlook and emphasis? Or does it present the full range of views and theory, exposing the student to all of the unresolved contradictions and controversies? A second issue concerning didactic teaching has to do with timing. Should a trainee be exposed to conceptual ideas about groups before or after he has had personal experience as a patient, as an observer, as a therapist? The third point concerns the use of didactic teaching in conjunction with other methods. Should the material which is read or heard then be discussed in seminars? Can a theory best be tested and assimilated by applying to groups what has been observed or conducted? Can exercises be devised to help the trainee compare and evaluate different theoretical approaches?

It is not unusual for students to be more confused than helped by exposure to diverse theoretical ideas and to controversy. The decisions about when and how didactic teaching is to be introduced, and how it is to be supplemented, are crucial in determining whether diverse ideas will contribute to confusion or clarity.

2. *Participant learning: the trainee as patient or group member.* Placing trainees in therapy groups, T-groups, or study groups is being done with increasing frequency. The use of group therapy for training is based on the assumption that what is to be learned has to do with the personality characteristics of the learner. It is assumed that the learner has certain lacunae or certain maladaptive patterns which must be confronted, modified, or at least brought under conscious control in order for him to become an effective group psychotherapist. In groups the prime learning task is viewed as permitting the student to experience the member role so that he adds this perspective when he begins to function as a therapist. In some groups the learning is centered about experiencing the group *qua* group, and a major learning task is to understand the group as a social system. In practice, the effects of these kinds of group experience overlap: the patient in the therapy group learns something about group processes; the participant in a T-group or study group may recognize and revise maladaptive patterns.

A trainee who is placed in a group as a patient is not in actual fact in the position of a patient. He is not as anxious or as troubled as a bona fide patient, he is not pinning his hopes on the therapy or the therapist in the same way or to the same extent, and he knows that the

therapy group is part of his training and can thus use the "game" aspect of the situation to defend or distance himself in a way which is not available to the patient. An opposite hazard for some persons is the possibility of becoming too involved in the situation so that they truly use it for therapeutic rather than learning purposes, that is, they do not distance themselves *enough*.

The T-group (training group) or study group is a bit different: the trainee is not defined as a patient but as a participant or group member. He is not necessarily expected to correct maladaptive patterns as a result of the experience, but he is expected to become more aware of and sensitive to group events and phenomena by experiencing and simultaneously observing and thinking about them. The relevance of such an experience is not limited to therapy groups, for they are equally relevant to staff groups, classrooms, and the like, in fact to any small face-to-face group.

Although training in none of these types of groups is precisely like being a bona fide patient in a therapy group, the groups generate similar feelings and experiences. For example, they can provide the trainee with an understanding of what it feels like to be in a group interaction when the familiar structuring aspects (agenda, hierarchy, task, etc.) are lacking and when initial expectations seem almost deliberately to be ignored (the patient's complaints are not solicited nor is a curative program prescribed). Such experiences can provide ample opportunities to be in the role of the isolate, the deviant, the scapegoat, or to be the target for strong group feelings such as hostility. Being in these positions means that one can learn experientially what it *feels* like to be in them. From the participant-observer vantage point the trainee can learn about the operation of powerful group pressures which generate conformist responses or spread unpleasant emotionality and how difficult it is to withstand or to modify these.

As a therapist one is the authority, but as a member of such a group one contends with the authority. How one relates and is perceived as relating from these different perspectives can be an "eye-opener." Unfortunately, it is an experience which surprisingly many group therapists fail to have in the course of training.

There is more to this issue than effectiveness and knowledgeability. When the trainee feels that upon him as group member devolves a share of the responsibility for the conduct of the group, that his behavior is

visibly influential in its up and down swings, and that he can be as vulnerable as the patient, he understands more fully what being a group patient means and he can be more responsive to his group patients.

In our view, however, the experience of being in a group is not enough. Opportunities to reflect, think over, and study are necessary in order to grasp the complexities of the group situation, the nature of one's own participation and feelings, and the impact of oneself upon others and others upon oneself. Perhaps the issue is more easily resolved in a T-group or study group, for here reflection about the process is seen as a legitimate and necessary part of the process itself. In a therapy group the problem is more difficult, for there is always the argument that to stop and reflect about the process is to interfere with it. In either case, such devices as post-mortems and tape-listening could conceivably be used.

3. *Vicarious exposure to groups through tapes, films, transcripts, or the observation of live groups.* It is possible to set up learning situations which simulate the real thing, through showing films, playing tapes, reading transcripts, etc. The advantage to the trainee is that he can do one thing at a time: rather than being required to understand and grasp the import of the group interactions *and* respond on the spot *and* be responsible for the conduct of the group, he can concentrate on the single goal of attempting to understand. Tapes and films have the advantage of being able to be stopped: a trainee can hear or see an episode which the supervisor considers critical or difficult to handle, the tape or film can then be stopped and the situation discussed. The trainee can be led to think about the kind of intervention which is appropriate, or the kind which might be a mistake, and in either case predict the likely consequences for the group and specific patients. One can then resume the tape or film and discuss what actually *did* happen. The disadvantage, of course, is that the material is "cold"; the trainee does not experience the situation in the same way that he would if he were actually in the real situation.

Observing live groups, participating in groups, and being the therapist for a group constitute very different perspectives from which to try to relate to group therapy. The latter two involve the trainee so directly and so overwhelmingly that he is hard put to "figure out" his strategies. They flow more or less spontaneously, they may be excellent or poor, but they are usually instantaneous responses to the demands of the

situation. Observing a group is quite different in its emphasis upon the cognitive: the observer is far freer to engage in diagnostic speculation; indeed this is one advantage of observation. But by this very "objectification" of the patients who are interacting, the observer comes to regard them as actors, as players in a fascinating drama. Consequently, one of the temptations of the observer role is to "script" the patients, to anticipate certain behaviors and to be disappointed if the predictions are unfulfilled. Observing, particularly through one-way vision screens, tends to reduce empathic responses to individual patients to the extent that it generates the tendency to see members predominantly as functional parts of a unit.

Nevertheless, it is certainly true that no adequate substitute exists for the conceptualizing vehicle of group observation. The "caveat" we mentioned can be taken account of by making sure that trainees have opportunities to rotate through more than just one of the training media, with experiencing, directing, or vicarious exposure, such as observation, used as supplements to one another.

True, the observer does not have the responsibility of acting. Also, he cannot stop the action and reflect on it; he must wait at least until the session is over. If he is in the same room with the group, he cannot discuss events as they proceed, and he must to some extent control his nonverbal reactions so as not to distract the group. If he is watching from behind a one-way screen, he can comment as the group moves along, although again he cannot stop the action. However, in either situation, he can check afterward with the therapist, comparing his formulations of the meaning of events with those of the therapist, questioning the therapist as to his intentions, comparing impressions of the impact of interventions on the group, etc.

4. *Role playing and exercises.* A wide range of exercises and role-playing situations can be devised, keyed to a number of training needs. For example, a group of trainees can be asked to write down problems they anticipate they will have as group therapists. They are then grouped into pairs and asked to share as much as they can of these problems with their partners. Following this, they are asked to form themselves into a large group and share the same problems. This exercise has the two-fold purpose of, first, getting the trainees to reflect about their potential problems as group therapists, and, second, enabling them to experience the different quality of sharing under pair and group conditions.

A group of trainees can be asked to role-play a therapy group, with one of their members acting as therapist. Such a simulated situation can be surprisingly realistic if each person taking the role of a patient is asked to keep in mind a particular patient whom he knows well and to behave in character with that person. After a short period of role-playing, the trainees form themselves into a discussion group to talk over what occurred in the group and how the therapist dealt with the situation. The exercise can then be repeated with someone else assuming the therapist's role. Many variations of this exercise are possible: for example, by varying the instructions to the group, typical problems can be presented, such as an apathetic group, a dominating patient, and the like. During role-playing, a trainee can practice conducting group therapy in a live situation without actually having to assume responsibility for an ongoing group of patients.

Another possibility is for trainees to be divided into pairs to observe a therapy group through a one-way screen. Each pair is asked to observe the group interaction from some particular theoretical point of view. Afterward, they can compare their formulations and consider whether and in what way the adoption of differing theoretical approaches would have led to different behavior on the part of the therapist.

Another exercise has been successfully used for training purposes by one of us. Each of the trainees in a group of seven was given the therapist's role for a period of two hours. However, the "action" was halted periodically—every twenty minutes or so—for a "clinicing" session with two senior therapists who observed the group. Feedback by the supervisory therapists could be used by the trainee-in-therapist-role to try out various strategies of intervention as he saw the opportunity to make them.

The above should be regarded merely as examples, for the possibilities are almost endless. One caution, which is particularly applicable to role-playing, should be mentioned. If an atmosphere of mutual trust and acceptance has not been established within the group of trainees, and if unresolved problems are still present having to do with competitiveness, resentment of the training staff and the program, etc., a role-playing situation can constitute an invitation to act out. The role-playing episodes then lose their value as a training device and become merely an opportunity for catharsis or for establishing nonconstructive solutions

(scapegoating, ridiculing group therapy, and the like) to problems existing within the trainee group itself.

5. *Apprenticeship learning, in which the trainee is co-therapist or therapist under supervision.* Many technical variations are possible here. The trainee may function as a co-therapist with the supervisor; two trainees may function as co-therapists; or the trainee may conduct a group on his own and have a supervisory session for every therapeutic session. The discussion between the supervisor and the trainee(s) may be based on verbal reports drawn from memory, on verbal reports drawn from notes, on a tape of the session, or the supervisor may have observed the session or parts of it through a one-way screen. Many of the problems of supervision are not specific to group therapy but are familiar also in supervising individual therapy: problems of keying the supervision to the ability and skill level of the trainee, establishing the boundary between supervision and therapy, dealing somehow with the dilemma that one can only discuss what has happened in the past and yet needs to prepare the trainee for dealing with the unpredictable future.

The supervisory model for the group therapist trainee will more than likely be the dyadic one, in which event the authoritarian and authoritative relationship engendered by our usual training modes will be in conflict with many of the potent aspects of the group itself. Let us examine the question of "reality definition," for example. In the therapeutic group there are many contending sources and some of these afford fresh looks at old problems or novel perspectives on long-term dilemmas. By contrast, a "this-is-the-way-I-do-things" approach sets up apprenticeship and imitative tendencies. The supervisor's experience and know-how are assimilated as craft and as value, but the trainee is not liberated to try and err. We do not mean to imply that individual supervision of group therapy trainees is a mistake but to suggest that such supervision in the absence of supplementary or even countervailing group supervisory experiences can only stamp in a mentor's approach and not exploit the range of possible group learning experiences.

6. *Seminars and discussion groups.* Discussion is likely to appear as a supplement to almost any of the training devices discussed so far. A book is better assimilated if it can be discussed with others; to observe a therapy group without a chance to discuss one's impressions afterward with others is relatively sterile.

Apart from these supplementary uses, however, at least one other possible use of a discussion group comes to mind. It was suggested earlier that to place a trainee in a therapy group leaves something to be desired, for it can never approach the real experiences of fear and hope which are felt by a bona fide patient. Yet everyone has had the experience in his or her life of despair, hope, fear, etc., and of the very sorts one expects to occur in a therapy group. Everyone has had a variety of group experiences. It could be very useful through group discussion to reach back to experiences in one's own life (e.g., first day at school, etc.) to help one to empathize with the experiences of the patients.

Discussion groups can fulfill two quite different purposes: first, to assimilate intellectually something to which one has been exposed, and, second, to recall and explore situations which one has previously experienced. In the first instance, the discussion group must supplement something else. In the second instance, it can stand on its own, with appropriate input from a discussion leader to steer it in the most useful direction.

PART III. DESIGNING A TRAINING PROGRAM

We have listed the issues involved in the training of a group therapist and we have described their relationship to the problems of skills and attitude development. We have predicated the consideration of these upon the central idea that the processes of group psychotherapy are unique and distinctive in many ways from other forms of therapy. It should be clear that much of the learning of technique and the didactic experiences which the mental health professional gets in his other training activities has no necessary transfer to group therapy practice. On the contrary, there is the likelihood that practices that are good and sufficient in work with a single patient may be inimical to the successful conduct of a group.

We have alluded to such aspects as the many-to-one relation, the difficulty of achieving one-to-one empathy in a group setting, the ubiquity of group forces, and the multiperson orientations of the therapist. Even the hallowed supervisory practices of dyadic psychotherapy may require "unlearning" in assuming the group therapist-role effectively.

In the face of this difference in emphasis, the training institution must be willing to ask itself how seriously it has invested in group therapy

training, whether its training program adequately recognizes the discontinuities of the various therapies and is willing to devote the time, manpower, and other resources necessary to do a good job of training.

Having listed a set of training needs and discussed a series of possible training procedures and their relevance to the list of needs, there still remains the problem of designing a training program: deciding which procedures are to be used, in what order, in what combination, and to what end. Having said in the beginning we did not intend to prescribe a training program, we shall not do so now because many combinations and orders of priority are possible. What is suitable to one trainee population may not be applicable to another. Also, the supervisor-apprentice relationship can appropriately be regarded as one of a number of possible training devices, one which comes at the end of a series of other training experiences rather than one which comes at the beginning or which constitutes the only training procedure.

In designing a program of training, it is important to recognize that many training needs can be touched upon or dealt with within a number of training contexts. Often, no single training context is exactly suited to a particular need but can make some contribution to it. As an example, consider the need to become aware of one's own fears in a group. Such awareness could emerge in the course of participating as a patient in a therapy group, or as a member in a training or study group; it may emerge in exercises; it may become apparent only when the trainee assumes responsibility for a group for the first time. The same may be said of many of the other needs which we have identified. All this suggests that the value of a program does not lie exclusively in its design—suitable training experiences introduced in a suitable order—but in the attitudes and teaching skills of the training staff, for if the mentors are aware of the training needs, they will be alert to opportunities to meet them in whatever training context. Offering a variety of training experiences can be expected to increase the likelihood that a number of training needs can be touched upon, but the real effectiveness of operation of group therapy practice will depend on the extent to which the training staff is sensitive to the training needs of the learner and can effectively exploit the full range of training procedures to this end.

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Analytic Group Therapy with Psychotherapists

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IT HAS BEEN SAID that there are three stages through which a psychiatrist passes: young psychiatrists talk about their cases, established psychiatrists talk about money, senior analysts talk about themselves. After forty years of work in psychiatry and thirty years in psychoanalysis, I presumably am ripe for the third stage, and accordingly I should like to discuss the renewed interest with which I have turned to group psychotherapy.

This turn is a result of continued introspection and examination of my work as a psychotherapist and as an instructor of psychotherapists. A friend of mine once overheard a senior colleague confess with some embarrassment to another great teacher of our profession that he felt fed up with supervision because for many years he had taught little children how to spell cat and they still did not know how. Recently, I had the chance to observe the development of six capable young psychiatrists while in training. I saw them through almost three years of twice-weekly group sessions, and it was my impression that they learned a great deal, perhaps even more than they would have learned in the same time in individual psychoanalysis. By learning I mean they gained understanding of themselves and insight into each other and their interaction, both consciously and unconsciously. This learning was stimulated by interpretation and by the emotional experience of honest and free response in the group. They experienced their relationship to me as a central figure

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as they would have done in a one-to-one relationship, but they also experienced the relationship to each other, thus including peer relationships in the learning situation. A threefold transference relation developed in the group: to me, to each other, and to the group as a mother figure. Insight into the dynamics of interaction, including insight into the psychogenesis of emotion and motivation, was stimulated by interpretation and response.

This group of young doctors did not differ greatly from a group of experienced analysts who before, during, and after their training had all undertaken long, repeated, therapeutic, didactic analyses officially terminated as "successful." With growing analytic sophistication, they all realized that the one-to-one relationship was not enough to have given them a satisfying and lasting therapeutic experience. They all had learned to master the one-to-one relationship, frequently in the service of resistance. They had learned to handle and manage their different analysts and to block further progress effectively. The change from the analytic isolation to the group experience and a peer relationship succeeded in continuing and deepening the analytic process which they had started in their analyses and carried on in their work.

It seems to me that one analyst is not enough for the analysis of an analyst. This has been known, and repeated analysis by different analysts has been recommended and tried (Kubie, 1968). But analysts learn how to deal with their analysts and how to disarm them in the service of resistance. It is my experience that another analyst is not the solution to this phenomenon. Neither is a friend able to continue the analysis of an analyst where his training left off. In such a friendship, as important as it may be, there is too much affection, too much relaxation, too little freely expressed hostility, and not enough working through of the transference phenomena.

A new transference situation is needed, as provided by the "one of us" relationship. The transference of peers to each other and to the group as a mother image is needed in order to analyze the analyst within the family transference. Most analysts growing older in their profession lose that kind of trust and confidence and faith in their colleagues which they had when they started as young men and accepted analysis in relation to older training analysts. As we grow older, a certain therapeutic skepticism takes hold of us. In the one-to-one relationship this skepticism becomes very strong. It is my experience that it is easier to re-

activate confidence and trust in a group relationship than in an individual setting.

DEFICIENCY IN PSYCHOANALYTIC TRAINING

An ever deepening criticism of analytic training has been apparent recently (McLaughlin, 1967; Greenson, 1965; Dorn, 1969; and Kubie, 1968), the main burden of which is that we have failed in the therapy which is a part of training. Clinical evidence that this is so is given by the majority of analysts and the pathology of analytic group behavior.

The old problem of negative transference and hostility in training analysis has remained a central, controversial issue. It is not just a transference problem. It is also a realistic problem. The patient wants realistically to be like his analyst and therefore he postpones most criticism and much of the negative transference until he is through with his training. Then, as a rule, it hits him with great force and leads to all kinds of personal problems internally and to manifest problems in interaction with his colleagues. The analyst carries his unresolved hostility into the family of analysts, and a repeated analysis helps little.

The problem of the analysis of negative transference is also a countertransference problem: fathers want to be loved by their student-sons who represent the future. Therefore, they relate differently to their training candidates in action, behavior, and interpretation than to most of their other patients. Kubie (1968) once discussed these problems and confessed that the transference is never really dissolved in a training analysis. As a remedy, he asks for a kind of "real relationship" in the form of a controlled, disciplined, low-intensity friendship. He also suggests a second analyst during the terminal stage who can take a better look at the leftover transference to the first analyst. Other analysts talk about a "working alliance" or "spontaneous responses" supposed to fulfill the individual demands and needs for a real relationship to the analyst.

It is my experience that the group offers help in the final resolution of negative transference relationships despite, or perhaps because, there is not simply a continuation of the analytic transference but a family transference. In the group there is a freer expression of hostility than in the one-to-one relationship. A younger man does not wish to attack an older man who represents more or less a professional ideal, and an older man has learned from experience how to be careful with a colleague.

But in a therapeutic group these regards are unnecessary and are carefully interpreted as defensive. The members can freely dish out hostility and the therapist, or, as I prefer to call him, the central figure, can freely respond to it. The members, knowing that their peers share their feelings, are encouraged by the fact that they will not be isolated in their hostility. The central figure, on the other hand, is much freer to accept hostility (before it is interpreted) since he knows that rarely will the entire group join in hostile rebellion. The central figure can also much more freely express his hostility and counter-hostility in a group, since he can trust the group to control his responses if need be.

THE RETURN OF THE UNANALYZED, REPRESSED FAMILY NEUROSIS IN THE FAMILY OF ANALYSTS

Analytic training liberates the individual analyst in training from the tyranny of his unconscious, but his "family romance" remains largely unanalyzed. How is this defect corrected by the group experience? The transference of the infantile past into the psychoanalytic situation is accomplished in the setting of individual analysis but then repeated and deepened in a different way through the transference of the "family romance" into the analytic group situation. There it can be experienced, interpreted, understood, and integrated. Freud may have known this; the Minutes of the early meetings of the Viennese Psychoanalytic Society show that these seminars were originally organized for the purpose of teaching psychoanalysis but that soon they assumed the character of modified therapeutic group sessions (Nunberg and Federn, 1967).

It is misleading to question whether the student's new analytic family is realistically dogmatic or not; it is an unconsciously motivated transference situation and therefore in need of being analyzed, which can best be done in the family transference setting of group psychotherapy.

The analytic group experience, as I envision it, gives a chance to the therapist in training and to the analysts in training institutes to analyze the repressed "family romance." The group process facilitates an analysis of a collective family transference neurosis. Although this final integration can be done without group therapy, it can be accomplished better and more effectively and much more "three-dimensionally" in the group. Such group experience could be the royal road to academic freedom and democracy in psychoanalysis.

THREE DIFFERENT TRANSFERENCE SITUATIONS
IN THE GROUP EXPERIENCE

The transference situation within the analytic group is threefold. There is a transference relationship to the central figure of the group which is formed approximately according to the transference situation in individual analysis. There is an equally strong—and sometimes even stronger—transference toward the other members of the group: the siblings, whether they be older or younger and of the same or the other sex. There is a third and very important transference which is especially clearly visible in groups of experienced analysts, and that is transference to the group as a mother figure.

The dynamics of the group process facilitate insight into, and interpretation of, the complicated and complex transference phenomenon. Every member of the group is both participant and observer, therapist and patient. He can at any time change from one role to the other, which offers new insight and new approaches to old defenses established in the one-to-one relationship.

Transference phenomena in the group, as compared to those in individual therapy, are not lessened or diluted or diminished or kept more realistic or quickly corrected. All these claims are partially true and partially not true—but beside the point. The transference is always different from the individual analytic situation since it is specifically, significantly, and essentially a family transference with the emphasis on the peer relationship to the siblings. The transference may be regressive; it may be progressive; but it is always seen in relationship to the "family romance" as transferred to the group. Parents tend to assume that, "Once a child, always a child," and training analysts tend to assume that candidates remain candidates forever (and sometimes this is true). Group psychotherapy facilitates the process of weaning on both sides, and in many cases the group experience is essential to this weaning.

It is possible that the group situation offers more transference gratification with less danger than does the formal or standard analysis. Not only may a member receive support and affection from other members of the group, but the central figure of the therapist can show affection or hostility to a higher degree and more spontaneously since he is always aware of the corrective influence of the group. He can express himself much more freely because the group renders the therapist not so power-

ful as he is in individual therapy. His power is replaced by the more flexible therapeutic pressure of the group.

The patient in psychoanalysis behaves like an only child; in a group the patient behaves like a member of a family with a number of children. As in a family, there are natural trends to growth and maturation which constitute effective and therapeutic group pressure.

FROM MY EXPERIENCE WITH DIDACTIC GROUPS

Young psychiatrists are inclined to use intellectualization as a resistance. An often heard phrase in a didactic group is: "We all talk like a bunch of smart professionals." However, the consequent avoidance of so-called intellectualization after it has been repeatedly interpreted may lead to a new form of resistance: insights are not properly formulated because they may sound too "intellectual" to a board of experts.

Psychiatrists in a group of colleagues have to learn how to replace questions by associative response. In the first stage of group formation, the members try to confirm their impressions and planned interpretations by fishing for more clinical evidence. They soon realize that their spontaneous response is more important and contains the proper interpretation. They then develop a final courage for human response, overcoming the handicap of the medical person who is suspicious of spontaneity and who has been trained to filter his responses carefully.

Work in groups of psychiatrists or psychoanalysts is tough for the central figure. However, it is excellent postgraduate training for the central figure as well as the members of the group. The therapist has to perform in the presence of six alert and specially trained critics. At times it almost amounts to a kind of board examination: anyone who passes such a test has received a real baptism under analytic fire. Only total honesty and sincerity saves the therapist. It is especially the analyst who has difficulty in allowing himself to feel his hostility (or his need for tenderness) who benefits. He can learn how to be more free, spontaneous, and responsive. The same group which exposes him will also protect him until he finds his way to an appropriate attitude. One can perhaps say that the psychoanalyst satisfies his need for intimacy in the one-to-one relationship, while in the group he satisfies his need for participation in the slow growth and maturation of a family.

At the beginning of my work with groups I was concerned about my inadequate knowledge of the patients' history making genetic interpretation difficult. I now use the time during the patient's preparation for the group to elicit this material, and I accept new members for a group only when I know them and they know me fairly well. I have also noticed that one knows much more about a patient after a while in the group than one realizes, and the more experienced I become, the less often do I request individual sessions for my information or clarification.

The group as the analytic mother allows a therapeutic alliance between members of the group which transcends the transference to the central figure. There is a courageous and honest attempt to deal in a free and spontaneous way with each other and with the central figure. Group members who are also colleagues become better team workers in institute, society, and research projects than they were prior to the group experience.

Some analysts whose seniority makes it almost impossible for them to consult other analysts develop that kind of mother transference to the group which they could no longer develop to a single person. Most of the men trust the group more than any individual analyst, and several men have revealed material which had been completely or partially withheld in their previous analysis; old narcissistic defenses, so frequently seen in training analysis, could finally be analyzed.

When working in groups, the analyst's narcissism takes a severe blow, which is necessary for final maturation. When he steps out of his professional isolation, he sees that he is not the only good analyst. He also realizes that he is not making many more mistakes than his colleagues. He may find that people whom he has not especially respected are quite different in the intimate interaction of a group, and this is a worthwhile human experience. After the group experience a new, humble and realistic attitude replaces his narcissicism and makes him a better therapist.

CONCLUSION

The analytic group experience in the later stages of psychoanalytic maturation has great therapeutic efficiency, since it emphasizes the experience, interpretation, and integration of a family transference. The analytic study of this specimen situation allows insight into the group therapeutic process in general.

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Conventional Group Therapy with Preadolescent Children

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THERE HAVE BEEN ONLY limited studies of the use of group psychotherapy with preadolescent children, perhaps because of the assumption that younger children cannot verbalize their thoughts and feelings with sufficient skill to make use of a discussion of their interactions with others (Slavson, 1944; Graf, 1958-59; Schneer et al., 1957; Carson, 1965; Little and Konopa, 1947). If verbalization of feelings is difficult for the preadolescent child, then one would expect the problem to be compounded in the lower socioeconomic class where verbal skills are presumably less well-developed (Bernstein, 1960-61; 1963; Christmas and Davis, 1965). Yet, there is an obvious need to reach a large number of such children with effective techniques that require fewer trained personnel than are necessitated by individual psychotherapy.

In an attempt to deal with some of these problems, a project of group psychotherapy was undertaken among fifth- and sixth-grade students of two inner-city schools in the Baltimore, Maryland, public school system. The therapy sessions were conducted on school premises and during school time to insure reasonable attendance without requiring parental involvement. The evaluation of each child referred for treatment was purposefully superficial in an attempt to see if treatment could succeed

without the usual extensive intake evaluation. No play equipment was provided, for one of the goals of the study was to see if children in this age range (10 to 12 years old) could be treated by a conversational group therapy technique. Finally, an attempt was made to evaluate the results of this treatment by comparing the progress of children treated by group psychotherapy to a similar group of children who met at the same intervals for supervised art activity.

SUBJECTS

The students chosen for this project were selected from two public elementary schools located in close proximity to the Johns Hopkins Hospital and serving a predominantly Negro community of very low socioeconomic class. The community conditions were characterized by the usual problems of overcrowding, broken families, and poor physical surroundings. After enlisting the cooperation of the administration, the fifth- and sixth-grade teachers of each school were asked to refer for treatment all of those pupils who presented problems in academic achievement or classroom behavior. Sixty children were referred. Each child was interviewed for about twenty minutes by one of the authors (A.B.). Then, as part of a larger project, each child was treated for six weeks with dextro-amphetamine sulfate and for another six weeks with a placebo in a double-blind crossover study of the effect of this drug on school behavior. Seven of the children dropped out of the study during this period; of the remaining 53, 23 demonstrated a definite favorable response to the medication, 16 showed minimal improvement, and 15 showed no change. It was our original intention to include in the group therapy program only those children who showed no change with medication. Because this left insufficient subjects for the study, the 16 children who responded minimally to the drug were also included. This made a total group of 31 children, 15 from one school and 16 from the other. The division of this total group into an art activity and a group therapy section in each school was made by the authors with the goal of forming groups that were comparable both in sex distribution and in number of withdrawn and aggressive children. When in doubt, there was a tendency to place the more severely disturbed children in the group therapy section. In one school there were two groups of eight children, each divided equally between boys and girls. In the other school, the art activity group consisted of

eight children, four boys and four girls, and the group therapy section contained seven children, four boys and three girls.

A very brief description of the presenting complaints in those children included in the group therapy sections will serve to demonstrate the range and kind of problems dealt with. These descriptions were obtained from the teachers' initial referral reports:

Group A. Jerome is said to be smart-alecky and a tattler, and he does not achieve as well as he should. James is often too quiet, seems unhappy, and is overly sensitive to reprimand. Shirley is obese and very shy, never volunteering in class. Barbara is easily upset and then becomes disruptive, with some very aggressive outbursts; she is the only white child in this class. William seems depressed and does not work up to his capacity. Denise is described as a puzzling personality for she is not close to anyone in the class though she is a pretty girl with a pleasing personality; also, she does not achieve as she should. Joseph is short-tempered, defiant, and frequently sulky; he cannot accept criticism and tends to show off.

Group B. Dwaine is a daydreamer, lies a great deal, and does not get along with his peers. Michael is described as stubborn, arrogant, and temperamental. Eugene is quiet but uncooperative and very argumentative with his peers. Deborah is wild, boisterous, and so disruptive that she cannot participate in a group. Henry lacks self-control, is an attention-seeker, and also a poor achiever. Michelle is very stubborn as well as a daydreamer with a very short attention span. Susie always demands her own way and gets angry when blocked. Genevieve is very bossy, being particularly domineering toward females.

METHOD

The group therapy sections met in the schools once a week for approximately fifty minutes. The authors were co-therapists of these groups. In one school a teachers' meeting room was used for the sessions, and in the other school meetings were held in the art room. In both settings the children and the therapists sat around a long table. The children were excused from class during the therapy session, and were expected to remember the time and the day on their own.

The art activity sections met once a week for fifty minutes in the same school rooms but at different times. These sessions were supervised by two art students, one male and one female, from the Maryland Institute of

Art. Several Art Institute students had expressed an interest in the project, and these two had been selected on the basis of their ability to work calmly with children. At each session these art students provided materials and suggested a particular project, such as cutting and pasting pictures from magazines or executing freehand drawings. However, the children were allowed relative freedom to pursue their own interests and were given appropriate practical assistance for any work they chose to do. Both art students provided an atmosphere of encouragement and were quite tolerant of individual differences; they made no attempt to interpret the children's responses or interactions nor did they encourage the children to talk.

Before the project terminated with the advent of the summer recess, there had been a total of ten art activity sessions and eleven group therapy sessions.

Meetings between the co-therapists and the teachers who referred the students were held at periodic intervals to evaluate the progress of the children in both the art activity and group therapy sections. A total of three evaluations was made. The first was held just before treatment began, the second about six weeks later, and the third just before termination. The teachers were interviewed individually. At the initial meeting they were asked to specify the characteristics of each child that they found most disturbing. At the two subsequent meetings, each teacher was asked about any general change and also was requested to comment on the course of the specific problems mentioned in the initial interview. Following each of these evaluations, a short note containing the teachers' comments was entered into the child's chart. At the end of the project, two members of the department, not connected with this study, read these evaluation notes and then rated each child's progress on a scale of zero to two. A zero was given for no change or deterioration, a one for slight improvement, and a two for marked improvement. These ratings were made without knowing whether the child had been in the art activity or group therapy section. When there was a disagreement on the ratings, the differences were discussed and the final rating represented a joint decision.

RESULTS

Table I shows the results obtained from rating the teachers' evaluation of each student's progress. Of the 14 children who participated in

group psychotherapy, eight showed marked improvement, six were somewhat improved, and there were no students who showed no change or deterioration. Two of the thirteen children in the art activity groups were markedly improved, six were somewhat improved, and five showed no change. The difference between these two groups was significant with a chi square at 8.69 ($p < .02$).

<div align="center">

TABLE I

Ratings

</div>

	0*	1	2
Group Therapy	0*	6	8
Art Activity	5	6	2

*Each figure represents the number of children who received this rating.

GROUP PROCESS

At the beginning session in both schools, the students were told that they would meet with us every week to talk together about problems they might have in school or at home. They were also told that anything discussed in the meetings would be kept secret by the group members.

At the first meeting in both schools, the children appeared on their best behavior as if surveying the scene to see what they might expect. In group A, one of the more outgoing children began to talk about some things that were happening to her at home and the others began to talk about similar situations in their own lives. Two of the shy children had to be encouraged to participate and tended to deny any problems. The therapists handled these early sessions by listening, trying to understand, and then stating for the group the feelings underlying the children's experiences. Expecting that trust would be an important issue in the beginning, this group was encouraged to continue a conversation about how long it would take to know whether you liked a new teacher. Several of the students said they could know in a day or two, but Denise, who was described as having no close friends, said it would take her several weeks. James, who was a perceptive child, commented that Denise could not trust people, and his statement was discussed. At the next sessions, Denise stated her intention of not talking and made obvious motions to withdraw from the group. The rest of the group was encouraged to discuss her response, which they did, but Denise only became more

stubborn. One child then stated that Denise had succeeded in obtaining the group's attention and suggested that she be ignored. This was done and Denise gradually rejoined the group and began to participate. Although the question of trust was partially resolved, it occasionally reappeared upon provocation. For example, after the second evaluation session with the teachers, a few of the children accused the therapists of breaking the rules of confidence. When a couple of weeks later the suggestion was made that a group picture be taken, a couple of the children were hesitant and the same issue was discussed again.

Following the first sessions, the group became rather boisterous. The children began interacting with each other, and, both individually and as a group, they began to test the limits of this new situation. Sometimes they would talk or tease in small groups, or as individuals they would withdraw to their own activity. Limits were established with the goal of preventing injury, destruction of property, or complete disruption of the group. Those children who withdrew could usually be drawn back through a request from the therapists or by exertion of group pressure.

At the beginning of the middle period of treatment, each child's defensive maneuver began to appear. The therapists continued to elicit the children's feelings about difficulties at home and at school, but now they also directed discussion toward the impact of one child's behavior on another and occasionally offered interpretations of defensive maneuvers. A few of the children began trying to exert some control over themselves and over the behavior of those who were disruptive. These attempts at control within the group occurred more frequently and were more successful as the meetings progressed. For example, Joseph, the most domineering child in the group, would hold the floor with a long story and would frequently interrupt others who were talking. With the passage of time the group learned to quiet him somewhat through the exertion of group pressure in the form of criticism of his performance. Denise gradually became a pillar of this group. She was frequently able to interpret sensitively the actions of others. She was also able to criticize Joseph skillfully and thus make it possible for the remainder of the group to organize around constructive conversation.

This group demonstrated a surprising ability to verbalize feelings and to understand the present as being partly a projection of past experiences. For example, during one session the conversation centered around a substitute teacher who was universally disliked. After describing her mean

behavior at length, the children were asked why someone might behave that way, and two of the children replied that people were probably mean to her when she was young. They also were able to draw out the shy child, Shirley, who was an obese and very quiet girl; she would talk if not interrupted, and the children learned to listen to her quietly. Later, after she had become more vocal, one of the children teased her and she was suddenly very quiet. Jerome noticed this and asked her if she was angry. Her angry reply was an encouraging sign of self-assertion.

During the final few meetings the group's response to termination emerged. Through Joseph's suggestion, the group talked about asking the therapists to have lunch with them. Instead, a party was planned for the last session. Group controversy arose over whether one girl, who had dropped out of therapy a few weeks earlier, would be invited. The children tried to settle the question on democratic grounds, but when it was clear that one child's feelings would be hurt, Jerome suggested that a group member's feelings were more important than whether the missing child was invited. Several of these children showed signs of regression to former behavior as termination approached. For example, James, who had been shy and passive at the beginning, became much more assertive during therapy, but during the last two sessions he again sought approval for his remarks and seemed overly sensitive to the criticism of others.

Although similar in broad outline, there were important differences in the course of treatment for Group B. During the first session, several of these students were anxious to air their complaints about the school in exaggerated language and with considerable affect. By contrast, the children in Group A almost never talked about the school itself.

After the initial session, which was fairly calm, Group B became disruptive and very difficult to handle. Two of the children, Henry and Genevieve, established a pattern of interaction that always resulted in complete disorganization of the group: Genevieve would accuse Henry of misbehavior, and Henry would respond with verbal abuse directed toward Genevieve. This progressed once or twice to the brink of physical attack which had to be quickly stopped by the therapists. During these battles, some of the children took sides and joined in the argument, but the rest were unhappy with the domination of the meeting and withdrew to other activities. Several times this pattern of behavior resulted in general chaos which could only be handled by posing the alternatives of quieting down or leaving the room.

Many of the children in this section did not seem to be able to control themselves enough to become involved in the group. They would wander around the room, talk in small groups, or insist on drawing with paper and pencil. Establishing physical contact with a child by touching his arm often helped to maintain attention, but too many of the children wandered about to make this method completely successful. Frequently, less than a majority of the children would actually be engaged in conversation.

Close to the end of the sessions some of these children verbalized their discomfort with the absence of rigid controls. For example, they stated a preference for men teachers who "don't let you get away with anything."

This group was never able to establish enough control to engage in a full session of talking therapy. However, it is of interest that twice, when absenteeism reduced the number of students to four, the sessions were quiet and productive. This was particularly surprising because two of the remaining four children had been most restless and provocative.

As it approached termination, this group showed little, if any, change during the sessions. The group as a whole had become somewhat disorganized, and perhaps the children were not sufficiently involved to feel the sense of loss. However, Michael and Eugene, who had responded the most to treatment, expressed angry feelings toward the group for blocking progress.

DISCUSSION

Therapeutic Goals

The therapists' anticipated goals were achieved with varying success in the two groups. It was hoped that the children would learn to recognize their own feelings about significant events in their lives; that they would become aware of the impact others had on them; and that they would be able to see the results of their actions on others. In Group A, at least some of the children made progress in each of these areas. In Group B, the children achieved some success only in the first area.

Today's emphasis on "comprehensive care" might suggest the desirability of careful intake evaluation and the importance of including the children's families in the treatment process. In this study, however, the initial evaluation was brief and parental involvement was limited to their giving permission for their children to receive drugs and to parti-

cipate in the study. Our decision was guided by the need to reach as many children as possible with limited personnel and to see how much could be achieved in the school. Each child's current difficulty in his classroom setting was quickly demonstrated within the group and with greater clarity than would have emerged from a long history-taking. We stressed the importance of the child's present behavior, and we did not become involved in his particular psychological and emotional development. We felt it was useful to meet in the school, during school hours, so that regular attendance could be achieved with little difficulty.

Theoretical Questions

One of the main questions posed by this study was whether children in this age range and from this socioeconomic background could verbalize their feelings with sufficient skill to benefit from a group therapy approach. Chigier (1963), using a plan very similar to that of the present study, reported success but used no comparison group and did not mention the children's ability to talk. Most authors reporting on group work with pre-adolescent children have used an activity group therapy approach, seemingly assuming that these children cannot control their impulses sufficiently to cooperate in a group endeavor and that they are not yet able to verbalize their thoughts.

The problem of using verbal communication as the basis of psychotherapy in children from a low socioeconomic class is compounded by their poorly developed verbal skills. Bernstein (1960-61, 1963) found that the relatively rigid social code of the English working class population has forced them to develop a restricted form of language and that this complicates the therapeutic process, which requires a sensitivity to shades to meaning.

Contrary to these indications, the children in this project demonstrated a remarkable ability to verbalize thoughts and feelings over a period of time. They possessed, as well, a sensitivity toward the feelings of others and toward the strengths and weaknesses in each other. Providing for them an environment in which these skills were encouraged and rewarded, we saw them progressively emerging and improving. The poor development of verbal skills observed by Bernstein, as well as those observed in the studies of the American Negro of low socioeconomic class, suggests a failure by these classes to reward this kind of response.

Practical Problems

The most difficult problem that arose during treatment was the handling of aggressive behavior. Under circumstances of general chaos, the therapists were caught in a bind between the real possibility of collapse of the group and their wish not to be identified with the kind of authority that dominates the lives of these children. Slavson (1951-52) states that the therapist should be as permissive as possible. He feels that if "social hunger" is present, children learn to control their own behavior in a permissive environment after they have fulfilled a need to act out in a regressive manner. Glatzer et al. (1944-45) found that complete permissiveness resulted in chaos created by the more aggressive children, whose object it was to test the therapist, and they suggest that it is this motivation which should be discussed rather than the limits. Those authors who have reported on group therapy among severely disturbed children have spoken of the need for firm limit setting Schneer et al., 1957; Straight and Werkman, 1958; and Stranahan et al., 1957).

In our group work, the need to establish some limits seemed clear. One useful technique was that of physical contact, with the therapist placing a hand on the child. Other techniques used were humor, attempts to mobilize the opposition of the quiet members, and in Group B, the alternatives of leaving the group or conforming to its rules.

In Group A, restless motor activity diminished with time and was no longer a problem toward the end of treatment. In Group B, the percentage of aggressive children was larger, and much of their aggressive and disruptive behavior arose from their inability to attend to anything that did not involve them directly. This suggests that groups having a number of aggressive children should be kept small, a conclusion supported by the change in behavior when only four of the children were present. In a large group in which there are only one or two aggressive children the aggressive child is less likely to become frustrated and will learn to modify his behavior, a price he must pay for inclusion. In a small group he may be less disruptive because he needs to exercise less control over his urge to dominate.

An additional factor that may have contributed to the difference between groups A and B was the striking contrast in general atmosphere and in the degree of cooperation extended by the two schools. In Group B's school, an atmosphere of discipline was stressed by the administration

over all other values. Although the school appeared on the surface to be interested in our study, we found our efforts repeatedly frustrated by such impediments as having to fetch the key to the door of the therapy room every week, having children removed from the middle of the session to run errands, or arriving to find the whole class away on a field trip. In Group A's school, a genuine interest in the welfare of the individual student was stressed. Not only was the study accepted with enthusiasm but every effort was expended to make it succeed. In both schools, the underlying message was undoubtedly transmitted to the children and probably affected their response to therapy.

SUMMARY

Conventional group psychotherapy was employed in the treatment of a group of fifth- and sixth-grade children in two slum neighborhood schools referred because of difficult classroom behavior or poor academic performance. The goal of the project was to evaluate this technique with reference to both the socioeconomic setting and the age group of the children. The progress of these children, as judged by their teachers, was compared to that of a similar group that met in supervised art work but did not participate in group psychotherapy. Though some favorable change was noted in both groups, there was significantly greater improvement seen in those children who participated in the group psychotherapy program.

Some of the experiences of handling these children in a group are described and the practical problems encountered are discussed. On the basis of this experience some recommendations are made concerning group size and composition.

It was our conclusion that conventional group psychotherapy is of considerable value as a therapeutic tool in the treatment of children in this age range (10-12 years old) and from a low socioeconomic class.

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Coalitions: A Measure of the Differential Extension of Parental Perceptions by Delinquent Girls

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Numerous authors have indicated (Klapman, 1959; Schindler, 1951; Bach, 1954; Hersko, 1962; Spitz and Kopp, 1963; Durkin, 1964) that the suitability of the therapy group to the working out of interpersonal conflicts is predicated, at least in part, on its similarity to the primordial family constellation. Wolf and Schwartz (1962) may be representative when they state that "the group recreates the family unit in which the patient can more freely reanimate the impelling and denying emotional demands whose contradictions he was once unable to solve." The likelihood that in the group setting transference reactions will occur and be subject to therapeutic manipulation is considered by most therapists to be a major attribute of group therapy. Even therapists who do not agree with the concept of the group as a family model (Slavson, 1950; and Foulkes, 1963) nevertheless view transference in the group setting as fundamental to therapeutic success.

Some authors (Orange, 1955; Hulse et al., 1956; Gans, 1962; Mintz, 1963) have supported the thesis that the more a group resembles a family, the more the participants will transfer basic conflicts onto the group. They see value in providing the group with co-therapists representative of a parental model. Mintz (1965) states, "It seems to be accepted as an

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axiom that every patient must work through problems originating in a two-parent family, and therefore joint treatment by male and female co-therapists seems a natural and almost inevitable development in psychotherapeutic technique."

There are authors, however, who do not accept this view. Berne (1966), in discussing co-therapists, states, "The idea that one represents a father and one a mother is theoretically presumptuous and clinically naïve. Experience indicates that what the presence of a co-therapist contributes in dynamic confusion usually outweighs what he offers intellectually or therapeutically." Slavson (1950) found the concept theoretically undesirable because of transference dilution. However, numerous articles have been published of attempts to make use of the concept of male-female co-therapists as parental models in a variety of clinical settings (Reeve, 1939; Lundin and Aronov, 1952; Linden, 1954; Sonne and Lincoln, 1966; and Singer and Fischer, 1967). Adolescent group therapy appears to be the area which has received the most attention in this context; male-female co-therapy has received comment by Perry (1955), Westman (1961), Godenne (1965), and Whitaker and Lieberman (1965). Schulman (1959) may be representative of this group, writing, "The presence of both male and female therapists in groups helps to allay anxieties in those youngsters who may be in extreme conflict with only one parent and often serves to reduce guilt since it can deter the development of a strong sexualized relationship with one of the therapists. MacLennan (1965), in a critique of co-therapy, illustrates the use of co-therapists with adolescents from broken homes to demonstrate how parental models function.

It is noteworthy that although numerous publications have appeared on the concept of the group as stimulating family transference and the use of male and female co-therapists as parental models, the majority are based on theoretical presumption and clinical observation. The authors were able to find only one article which attempted to show a transference phenomenon objectively in group therapy. In 1962, Berzon published the findings of a study designed to test the relationship between remembered parental conflict and the selection of persons with whom to initiate interaction in group therapy. She was testing the hypothesis that in psychotherapy group participants will initiate interaction with other participants to the extent that they are perceived as similar to the parent now remembered as the most threatening. Her findings did not reach statistical

significance, suggesting that residual parental threat is not an important influence on the initiation of interaction in group therapy. Berzon studied groups of mixed adults meeting with a single therapist, and it is possible that her hypothesis might have been supported if the groups had been structured in such a fashion as to more closely simulate a family unit. On that basis it would seem reasonable to test her hypothesis again in a situation involving male-female co-therapists in interaction with group members chronologically more representative of children in a family model setting. Prior to testing the hypothesis in a group therapy context, the following study was made to test the hypothesis that when a delinquent adolescent girl is required to operate in a triad with a male and a female adult, she will project parental attitudes onto those adults whom she perceives as parental models and that one manifestation of this will be her willingness or unwillingness to attempt to make coalitions with them. In essence, this study is considered a model for developing what might become a reliable index for measuring change in group therapy, particularly as it might relate to parental attitudes which are projected onto group therapists and how these attitudes differ throughout the course of therapy. The study attempts to answer these questions.

1. Is there a correlation between parental perceptions and perceptions of two adults in an experimental triad?

2. Is there a relationship between the above correlation and attempts to make coalition with the two adults in the experimental triad?

3. Is there a correlation between perceptions of the adults in an experimental triad and attempts to make coalitions with them?

The specific use of coalition attempts as a manifestation and objective measurement of projected parental attitudes is a method which the authors' review of the literature indicates has not been used before in the context of a simulated family triad with an adolescent subject and male-female adult experimenters. However, use in the present study seems appropriate based on evidence provided by Vinacke and his associates who studied coalition formation as a means of objectifying interaction in a variety of experimental triads (Vinacke, 1957, 1959, 1961, 1964; Chaney and Vinacke, 1960).

There are, however, several basic assumptions to be made in making a connection between coalition attempts and projected parental attitudes. These are identical to three of those stated by Haley (1962) in his work

using coalition formation to differentiate types of interaction in normal families and the families of schizophrenics:

(1) The millions of responses which family members meet within a family fall into patterns, (2) these patterns persist within a family for many years and will influence child's expectations of, and behavior with, other people when he leaves the family, and (3) the child is not a passive recipient of what his parents do with him, but an active co-creator of family patterns.

It seems evident that by now these assumptions have been reasonably confirmed by Haley as well as others. Thus, it seems that the use of coalition attempts as objective evidence of persisting family patterns is a practical way of demonstrating projection of parental attitudes in a simulated parental model setting. In this study the term coalition will refer to an alliance or partnership which may or may not be initiated by the adolescent subject with one of the experimenters in a competitive game context.

METHODOLOGY

Subjects consisted of 24 volunteer, Caucasian adolescent girls in residence at Scioto Village, a state correctional institute for delinquent girls under the auspices of the Ohio Youth Commission. They ranged in age from 15 years, 11 months to 18 years, 7 months, with 20 girls being between 15 years, 11 months and 17 years, 0 months at the beginning of the study. The mean length of incarceration at the time of the study was 6.2 months or less. All subjects had been charged with at least two offenses; these included incorrigibility, 19; runaway, 15; truancy, 12; and sexual delinquency, 12. For the majority, 15, this was their first incarceration beyond a few days in a place of detention at their home locale. An intelligence quotient was obtained for 20 girls, and the range was from 69 to 118, with a mean score of 93.9. The score was over 90 for 13 girls, and only one had a score under 82. Their case histories revealed a psychiatric diagnosis in 12 cases: passive aggressive personality, 4; adjustment reaction of adolescence, 3; sociopathic personality, 2; character disorder, 1; neurotic reaction, 1; and schizoid personality, 1. In terms of family exposure, 11 girls had lived entirely with both natural parents, and 11 others had lived entirely with one natural parent. Of the latter, 9 had also lived with a step-parent for at least two years. Three girls had lived

for less than six months each in foster homes. The father had a criminal record in nine cases and the mother in one.

The experimenters were a 26-year-old, married, Caucasian female and a 29-year-old, married, Caucasian male, both residents in psychiatry at the Ohio State University Hospitals.

EXPERIMENTAL TASKS

Following a brief orientation, subjects completed semantic differential ratings indicating their perception of their mother and father. This task as a means of measuring perception has been developed extensively by Osgood et al. (1957). It includes a list of polar adjectives presented randomly but divided for scoring under four headings: Evaluative (good-bad); Potency (strong-weak); Activity (slow-fast); and Justice (fair-unfair), the latter being arbitrarily added to Osgood's original three because of presumed adolescent sensitivity to that concept. Subjects rated their parents separately on 40 scales. For example:

<div style="text-align:center">

Concept (mother or father)

polar term, good 1 2 3 4 5 6 7 polar term, bad

polar term, fair 1 2 3 4 5 6 7 polar term, unfair

</div>

Scale positions are defined as 1, extremely good; 2, quite good; 3, slightly good; 4, equally good and bad or neither; 5, slightly bad; 6, quite bad; 7, extremely bad. Polar adjectives were randomly reversed throughout the 40 scales so that scale position 1 might be extremely negative and 7 extremely positive in terms of the heading. For scoring purposes, however, 7 points were given for the highest positive response so that a total score of 70 for the 10 scales under a heading would mean that the parent received the most positive rating on all 10 scales.

One week after the initial session and semantic differential completion, each subject participated in a coalition game with the experimenters. The game was a modified version of the one used by Vinacke and Arkoff (1957) and Bodin (1965) in their studies of triads. A total of twenty-four rounds were played with each girl and at the beginning of a round, each player was assigned a value for that round. There were three power patterns of values: all equal (1-1-1), one stronger (3-2-2), and one all powerful (3-1-1) as described by Caplow (1956). These patterns

were randomly distributed so that the 1-1-1 pattern occurred six times, and the other two patterns nine times each, with each player having the 3 value three times. The winner of each round received one hundred points. The winner was defined as the player or players having or obtaining the highest value for the given round. The subject was encouraged to try to win as many points as she could per round, and the experimenters declared that they would do the same. The subject could choose to make a coalition request to one of the two experimenters once per round. Her request could be rejected, but if accepted, the assigned values of both players were combined for that round. They became partners, using their combined score to compete against the other player and evenly dividing the one hundred points awarded if they won the round. The subject was told that the experimenters might or might not accept her request for a coalition, and she would not know if they had or had not. Based on her initial value for each round, she would have to decide which experimenter was most likely to accept her request. Subjects were told that the experimenters could not make coalitions with each other.

Players were seated around a table with three partitions. The subject operated a manual device which presented the power pattern for each round, and she was asked to read aloud the values for each player. Coalition requests could be made by pressing the appropriate one of two buttons in the subject compartment and these would illuminate a green light in front of the experimenter with whom she was seeking a coalition and simultaneously illuminate a red light in front of the other. Subjects could choose not to make a coalition by saying, "No deal." Both experimenters scored the attempts at coalition made or not made during each round.

Following the game session by one week, each subject met with the experimenters for a 45-minute interview which was relatively nonstructured. Topics of conversation usually included the girl's feelings about the institution, how she happened to come there, and what her parents were like. At the end of this session, the subject completed the same semantic differential task described previously, only this time the two experimenters were the subjects to be rated.

Tables I and II are directly relevant to the first part of the hypothesis which is presented in the form of question 1: "Is there a correlation between parental perceptions and perceptions of the two adults in the experimental triad?" Correlation between the four semantic differential

TABLE I

Correlations between the four semantic differential scale scores of female experimenter (columns) and female parent (rows)

Female Experimenter

		Evaluative	Justice	Potency	Activity
	Evaluative	.18	−.03	−.12	−.13
	Justice	.34	.27	−.11	−.05
Female Parent	Potency	.34	.20	−.12	.25
	Activity	.05	−.07	−.05	−.19

No correlations are significant using one-tailed test. Degrees of freedom = 22

scale scores of the experimenter and the parent of the same sex should be significantly greater than zero if the null hypothesis is to be rejected. Only the potency scale score correlation between male experimenter and male parent was different from zero. Therefore, a relationship between parental perceptions and perceptions of the experimenters cannot be assumed and question 1 must be answered negatively.

TABLE II

Correlations between the four semantic differential scale scores of male experimenter (columns) and male parent (rows)

Male Experimenter

		Evaluative	Justice	Potency	Activity
	Evaluative	.31	−.03	−.09	−.02
	Justice	.32	.03	−.16	.19
Male Parent	Potency	−.04	.42	.38*	−.15
	Activity	.10	.17	−.28	−.08

* $p < .05$ (one-tailed); degrees of freedom = 22

Graph I presents the data directly relevant to the second part of the hypothesis as presented in the form of question 2, "Given a correlation between parental perceptions and perceptions of the two adults in the experimental triad, is there a relationship between this correlation and attempts to make coalitions with the two adults in the experimental triad?"

It must be stated at this point that since the null hypothesis of question 1 could not be rejected, the second part of the hypothesis, as stated

above, becomes theoretically unimportant because there is no basis to infer an association.

The analysis of the data seen in graph 1 was accomplished according to the following procedure. For each of the four scales of the semantic differential task, and also for the total score on the 40 semantic differential items, the subjects were divided according to whether they rated

GRAPH 1

FATHER > MOTHER   FATHER < MOTHER

MALE
FEMALE
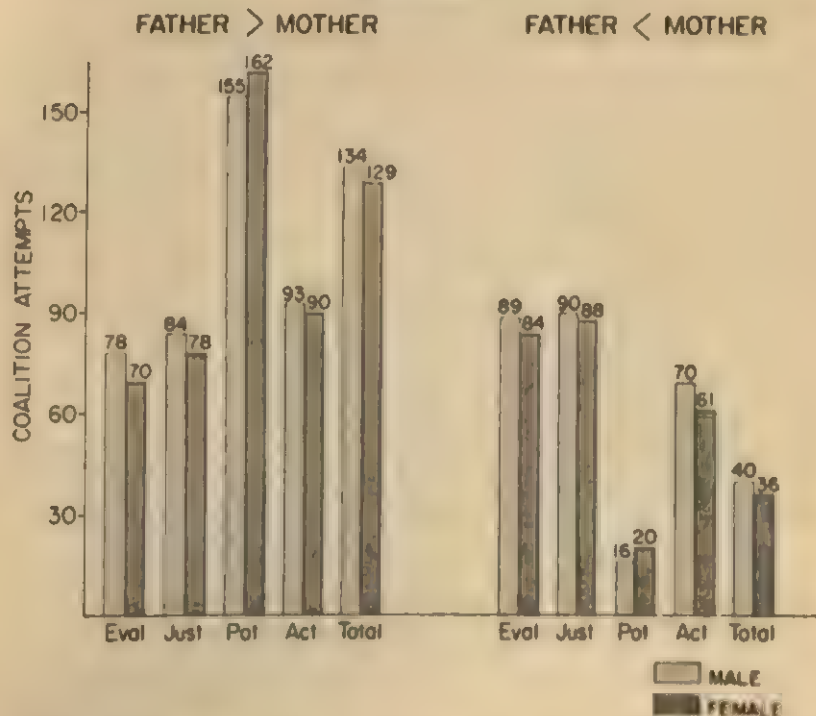
father higher than mother or father lower than mother. The number of coalition attempts by the girls in each category was summed. Because the power patterns of the twenty-four rounds were balanced, coalitions attempted strictly on the basis of the power patterns should be equally divided between the two experimenters, and differences in total coalitions attempted should be due to factors other than the power patterns. As seen in the graph, regardless of the scale scores, coalition attempts are equally distributed between both experimenters. Chi-square was computed for each distribution and values obtained were extremely low, as might be

expected from looking at the graph. Thus, the semantic differential scale scores of the parents do not demonstrate any predictive value in terms of coalitions attempted with either experimenter.

Graph II presents the data directly relevant to the third part of the hypothesis as stated in the form of question 3, "Is there a correlation between the perceptions of adults in an experimental triad and attempts

GRAPH 2
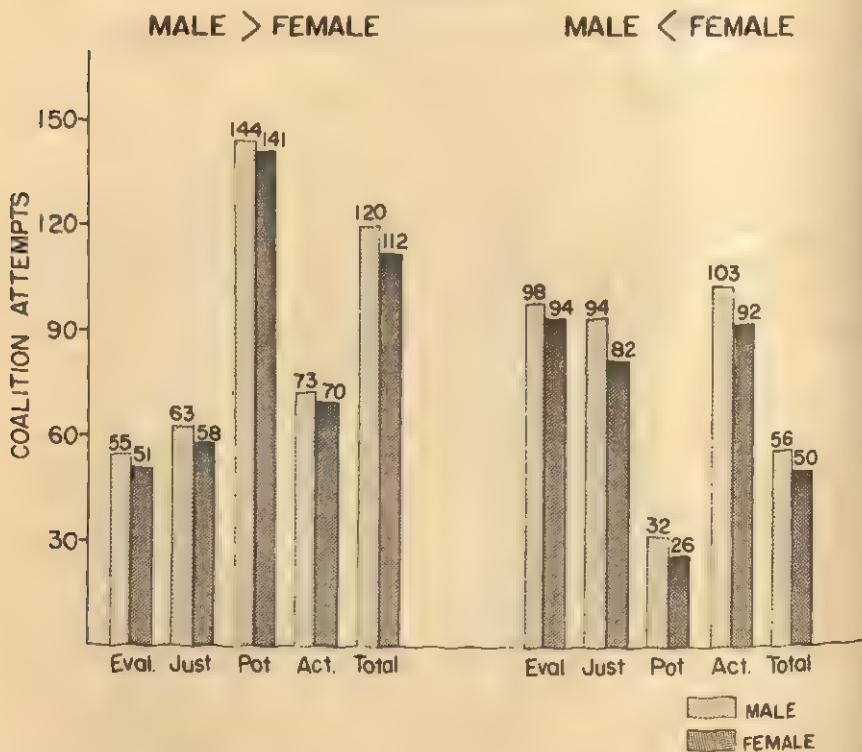
to make coalitions with them?" The analysis of the data was accomplished according to the same procedures described in relation to graph I. Again, there is a remarkably even distribution of coalition attempts regardless of the semantic differential scale score. Chi-square values were computed and again found to be very low. Thus, in terms of question 3, semantic differential scale scores for the male and female experimenter showed no predictive value in relation to coalition attempts with either experimenter.

Since none of the semantic differential scale scores for parents or

experimenters was able to predict coalition attempts, it was decided to test the power patterns themselves as predictors. Where applicable, the hypothesis of Caplow (1956) as confirmed by Vinacke and Arkoff (1957), was used. However, the nature of the game was different from that of Vinacke and Arkoff in that only the subject could request a coalition, the subject was not informed if the request was accepted, there was bartering for a greater share of the winnings, and the subject knew that the two experimenters could not make a coalition with each other. Therefore, several of Vinacke and Arkoff's hypotheses were modified. Table III presents the data. In the all equal (1-1-1) pattern, Vinacke and Arkoff's hypothesis of evenly distributed coalition attempts is supported. In the subject all-powerful (3-1-1) pattern, Vinacke and Arkoff's hypothesis of few coalition attempts evenly distributed is supported. In the subject more powerful (3-2-2) pattern, because of the game modifications, this becomes identical arithmetically to the subject all-powerful pattern (3-1-1) and results are the same, with few coalition attempts evenly distributed. In the female experimenter all-powerful (1-3-1) pattern and the male experimenter all-powerful (1-1-3) pattern, Vinacke and Arkoff's hypothesis of few coalition attempts evenly distributed does not apply because of the nature of the game. Here, the expectation would be more coalition attempts directed to the all-powerful player with 3, and this was supported by the data. In the female experimenter more powerful (2-3-2) pattern and the male experimenter more powerful (2-2-3) pattern,

TABLE III

Number of coalitions attempted with male experimenter and female experimenter in each power pattern

	1-1-1	3-1-1	1-3-1	1-1-3	3-2-2	2-3-2	2-2-3
Male	38	6	11	46	10	33	38
Female	40	12	42	7	16	28	25
Total	78	18	53	53	26	61	63
Total Possible	144	72	72	72	72	72	72
% Attempted	54%	25%	73%	73%	36%	85%	88%
X^2	0.051	2.00	26.50	28.70	1.38	0.41	2.68
P (df = 1)	>.90	>.10	<.01	<.01	>.10	>.58	>.10

In each power pattern the value of the subject is listed first, the value of the female experimenter is listed second, and the value of the male experimenter is listed third. The predicted frequency in each test was taken to be half of the total frequency. Yate's correction for continuity was used in computing X^2.

Vinacke and Arkoff's hypothesis of more coalition between the two weaker players is applicable but not supported by the data, which show no significant difference between coalition attempts with the experimenter with the three value and the experimenter with the two value. In both cases more coalitions were attempted with the male experimenter; however, this did not reach significance.

DISCUSSION

In trying to develop a model for measuring change in group therapy the contention of the authors has been that, as stated by the hypothesis of the study, when delinquent females are required to operate in a triad with a male and a female adult, they will project parental attitudes onto those adults whom they perceive as parental models. Furthermore, it was suggested that one measurable manifestation of this extended parental perception would be in the girls' willingness or unwillingness to initiate coalitions with the two adults in the context of a competitive game. Statistical analysis of results demonstrates that the hypothesis is neither supported in its entirety nor in any part. Results from the semantic differential do not show extension of parental perceptions to either experimenter, with the sole exception of one significant correlation between the male experimenter and the male parent on the Potency scale, Table II. The second part of the hypothesis, suggesting that parental perceptions would predict coalition attempts with the experimenter of the same sex, became theoretically unimportant in terms of the hypothesis when no significant correlation was found between parental perceptions and perceptions of the two experimenters. However, statistical analysis of these data was carried out, Graph I, and results demonstrated no predictive significance in terms of coalitions attempted in relation to parental perceptions. Finally, the third part of the hypothesis, suggesting a correlation between perceptions of the experimenters and coalitions attempted with them, also had to be rejected on the basis of the data, Graph II.

Thus, it must be stated that, at least in relation to the measuring instruments used in this study, no extension of parental perception was found and neither was the semantic differential useful in terms of predicting with whom girls would attempt alliances in a coalition game.

In addition to the obvious explanation that, in terms of the hypothesis, simply no relationships were present, certain retrospective remarks

seem appropriate for considering alternative explanations for the absence of findings. One consideration has to be the willingness of the girls to be honest about their perceptions when filling out the semantic differential items.

The generally favorable mean scores obtained for both experimenters and particularly for the parents are suspect, especially because of their lack of consistency with feelings verbalized by the girls during the interview situation and with case records about their parental relationships prior to institutionalization. It would seem that many of the girls did not want to show their parents in an unfavorable light and that also they were reluctant to record negative feelings about the experimenters.

Another factor to be considered would be the timing of the semantic differential on the experimenters, which took place at the end of the third session. In essence, what we were hoping to demonstrate was an initial impression of the experimenters based on Haley's (1962) second assumption that "family patterns persist within a family for many years and will influence a child's expectations with other people." In retrospect, it seems we gave the subjects too much exposure to us for them to have only an initial impression, while, on the other hand, they did not have enough extended interaction with us to develop any transference. From a methodological standpoint, it would also have been better to have measured perceptions of us first and then tested their relationship to coalition attempts rather than playing the game first and obtaining semantic differential scores on us afterwards.

In relation to the semantic differential task itself, there was evidence of overlap between many of the scales which frequently reached significance. Actually, it could have been expected that the girls would often attach different meanings to the polar adjectives used than those found by Osgood, who collected his data from groups of normal college students.

Certain remarks about the coalition game also seem appropriate. Although a trial run was provided to make sure that subjects understood the game, nevertheless, several indicated they had not until they had completed eight to ten rounds. Since there were only twenty-four rounds, eight errors would obviously have a significant effect on the accuracy of the data. In addition, many of the girls seemed to be quite aware of trying to be fair to both experimenters by making equal numbers of coalitions with both; this was not difficult for them to do with the small number of rounds and rejecting the first ten as a trial section.

In considering the power patterns as predictors of coalition attempts, in general, the findings (Table III) were consistent with those of Vinacke. The girls apparently did tend to respond more on the basis of perceived power pattern than any other factor. The only surprising finding in terms of Vinacke's evidence occurred in the pattern where the experimenters were more powerful (2-3-2 and 2-2-3). Here, more coalitions might have been expected between the subjects and the weaker experimenter. This is particularly true considering the game modifications which allowed only one coalition attempt per round, thus making it possible for the more powerful experimenter to refuse the request for a coalition and win the round by himself. In terms of rational game play, subjects should have made more coalition attempts with the weaker experimenter; however, Table III shows that attempts were rather evenly distributed. An individual analysis of these patterns indicated that the subjects divided into roughly two groups, half making coalitions always with the weaker experimenter as expected, and half making coalitions always with the stronger experimenter. Possibly the latter group did not understand the game, but another explanation might be that this group of girls were more power-oriented and therefore always sought alliances with the most powerful player regardless of the fact that rationally their request should be rejected.

SUMMARY

As part of a pilot study to develop a model for measuring change in group therapy, a semantic differential task and a modified coalition game were used to test the hypothesis that when delinquent females are required to operate in a triad with a male-female adult pair, they will extend parental perceptions onto those adults and one manifestation of this will be in their attempts to make coalitions with them in a competitive game context. Data were obtained from twenty-four girls who scored semantic differential scales on their parents, played a coalition game with a male and a female experimenter, and then scored semantic differential scales on the two experimenters. Analysis of data indicated that the null hypothesis could not be rejected. An explanation of the absence of correlations is offered with reference to experimental design.

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Group Sessions with Wives of Aphasic Patients

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In order to return the aphasic patient to as close to premorbid functioning as possible, we have felt it important to give family members a place on the rehabilitation team. One of our services to facilitate this has been group sessions for family members. The vast majority of those who attend the meetings are wives in their fifties or sixties. The group usually has been conducted jointly by a speech therapist and a clinical psychologist, but recently a physiatrist has been added as a third leader. Sessions are held weekly for one and one-half hours. A letter inviting a family member to the session is sent to the home of every aphasic patient accepted for treatment.

The first session begins with each member introducing herself and describing the patient's condition as she sees it. In this way the participants become acquainted with each other and with each other's problems. Patient differences in age at onset, degree of motor involvement, extent of speech impairment, etc., are revealed so that the participants realize immediately that every case is different. The introduction provides opportunity for the wives to exchange information and ask questions of each other and of the group leaders in a nonthreatening way. If the topic is anxiety-provoking, they can always use someone else's husband as an

example. A feeling of openness and give-and-take is thus established at the very beginning.

This emotionally supportive atmosphere enables the wives to ask a series of anxiety-laden questions. The first is usually, "Will my husband recover, and how long will it take?" The leaders point out how varied the individual stories are and how difficult this makes it to answer questions concerning prognosis. An even more anxiety-laden question is, "Has my husband lost his mind?" This kind of question can be responded to by distinguishing between what the wives think of as being insane and such other conditions as memory loss or impaired ability to communicate. Clarification of this kind reduces anxiety and encourages participants to explore additional areas.

When a patient is accepted for speech therapy, his family receives a copy of a booklet, *Understanding Aphasia*, prepared by the Institute of Rehabilitation Medicine of the New York University Medical Center, and the participants in the group usually read it avidly. Because we want the wives not only to understand aphasia intellectually, but also to feel what it is like, we encourage them to explore the condition phenomenologically. This has led them to describe aphasia in the following ways: "Aphasia is like going to a foreign country where you know only a few words"; expressive aphasia has been described as, "Like having a word on the tip of your tongue but you can't say it"; receptive aphasia has been described as, "It's like playing a tape recorder at the wrong speed." The wives search for everyday examples of automatic speech, as, for example, their husbands' saying "fine" in answer to the question, "How are you?" When they begin to explore the areas of reading and writing, the leaders explain that the problem is not a visual one but a perceptual one and one of abstract reasoning related to damage to the brain. When they understand perceptual difficulties, they often are able to document the discussion with examples from their husbands' behavior. One wife said, "Oh, that's why my husband tries to eat with the wrong end of the fork!" Exploration of this kind reduces anxiety, for once the wives know what aphasia is like, to cope with it seems possible. Moreover, during the exploration, the wives experience emotional support from the leaders and the other participants.

After this, the wives can turn from the specifics of aphasia to the emotional status of their husbands. It is at this point that wives generally begin to talk of such things as their husbands' dejected looks, excessive

crying, irritability, temper, rigidity, and emotional lability. The hyper-sensitivity and distractibility of some stroke patients are discussed, and the leaders point out that two conditions are probably operating simul-taneously. One is the emotional reaction to the stroke, and the other is that due to the brain damage itself. We discuss such things as disin-hibition, "childishness," catastrophic reactions, rigidity, and emotional lability as phenomena of damage to the brain. From the sharing of ex-periences, the wives see that it is not unusual for a stroke victim to show his feelings more directly than was customary for him before his stroke. This kind of clarification removes some of the emotional burden from these wives, for they come to understand that it is not necessarily their behavior that has precipitated their husbands' poor emotional state.

Once the wives have appreciated the communality of their problems, they can move from discussing their husbands to discussing their own particular reactions. We have observed in those wives who have sons that part of the complex of feelings formerly attached to the husband may become displaced to sons. Sometimes this displacement follows a forced financial dependence on the son; sometimes it is fostered by the regressive behavior of the husband. An illustration of this was the patient who now called his wife "Mama" instead of by her given name, which he had always used previously. Some wives look to their sons to replace their husbands. For example, one wife said, "My son is 30, and I used to urge him to get married; now I'm glad he is single." One of our wives, a woman in her forties, described sleeping one night with her son because of having house guests. She said that in the morning her son had said, "You are terrible to sleep with; you kept touching me with your foot; I had to keep moving away till I almost fell off the edge of the bed."

After the wives are able to bring out their feelings of frustration and loneliness, they then can admit to feelings of intolerance and impatience. They say such things as, "I can't stand it; he follows me around all day like a puppy dog"; or, "I haven't got a minute to myself"; or "I don't want to spend the rest of my life being a nursemaid." Statements of this sort are generally taken up and often added to by other participants. The wives come to feel that despite their husbands' disabilities, they too are entitled to have and to express feelings of impatience and annoyance. A direct consequence of the reduction in feelings of guilt that these wives thus experience is that the next topic spontaneously taken up is gen-erally that of keeping up their own morale. One wife said, "It is im-

portant to maintain your own spirits," and another wife responded with, "When you enjoy yourself, then you bring something back to him." The group usually concludes that each wife should have some time for herself to do whatever she wishes.

As in more standard kinds of group psychotherapy, the sharing of experiences increases rapport among participants and they become very eager to help each other. On the practical side, one wife, whose husband was primarily an expressive aphasic, brought in the various forms she had had to fill out to qualify for membership in a library of talking books sponsored by an association for the blind. Another wife brought in a craft book that contained masculine-type activities that her husband had been willing to do and which kept him occupied for a number of hours each day. On the emotional side, we have observed members leaving sessions arm-in-arm. One wife who had attended a previous series said to a wife who was attending her first session, "I can talk now, but how stunned I was at first! Now I am able to live from day to day; it's sort of like this is my life now."

New members are allowed to join the group at the beginning of any session. The new participant stimulates the others and also provides them with a standard against which they measure themselves. By contrast with a new member, they spontaneously experience how much they have adjusted since their husbands first became ill. Another way these sessions differ from standard group psychotherapy is in the amount of information provided the participants. For this kind of group, giving information increases the sense of being able to cope, which, in turn, increases motivation to participate in a group process that can then take a more psychotherapeutic turn.

Our experience over the past fifteen years with groups of spouses of aphasic patients has enlightened us about some of the factors involved in the management of a severe physical disability like aphasia. One salient factor is the breadth of the aphasic's problems, many of which are not evaluated by means of standard psychological tests. Another is the importance of time as a major feature in adjustment, not only for the patient himself but also for persons emotionally close to him. Another important aspect not given really sufficient attention in rehabilitation and in medicine generally, for that matter, is the wide ramifications severe disability has on persons significant to the patient. Viewed in this light, any specific therapy, like speech therapy, is only one small aspect of the

patient's rehabilitation. It would seem that rehabilitation centers should broaden their services to include families to a much greater extent than they now do. Group sessions with families of disabled patients are an important adjunct to the total rehabilitation of the person.

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Co-therapy: The Relationship between Therapists

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WHEN CO-THERAPISTS LEAD A group, the relationship between them is a significant dimension of the group's climate and therefore is an influential factor in the outcome of treatment. If co-therapists respect, trust, and like each other (in addition to being competent), group members stand a better chance of being helped than if they conflict with one another emotionally and/or intellectually. Yet the literature contains few statements about this relationship, and the situation today is the same as four years ago when MacLennan (1965) said ". . . there is no adequate discussion of the ideal or appropriate way in which therapists are to relate to each other . . ." This paper explores some of the features of the co-therapy relationship.

When co-therapists begin a group, they engage in an adventure of discovery about their own relationship. The adventure is like a marriage in its potential for both intimacy and conflict and the development of trust. The question—What changes are going to occur between us during the life of this group?—can stimulate excitement and apprehension.

The humanness of co-therapist experiences vis-à-vis each other becomes apparent when one reads about actual situations. For example, Gans (1957) reports interviews with two therapists-in-training. One feared dominating his partner and the other hesitated to intervene when his colleague's statements were unclear. MacLennan (1965) reminds us that a co-therapist may weary of his colleague's involvement with a pa-

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tient during group sessions. Solomon et al. (1953) comment that it may be difficult for co-therapists to separate their intragroup behavior from their extragroup encounters and they may displace strain between themselves onto patients.

Consideration of some intertherapist events may suggest principles which can serve as guides for co-therapists. Hopefully, no therapist allows principles to displace his ability to be spontaneous, i.e., to "relate live" with his partner, but in moments when a co-therapist must make decisions vis-à-vis his colleague, it is unrealistic to rely entirely on intuition or to hope that private conferences will always resolve prior and anticipate future predicaments.

DEVELOPING THEIR RELATIONSHIP

At the group's first meeting several administrative matters had to be settled. Announcements had to be made about time and place, papers needed to be distributed, and a roll had to be taken. One leader seemed to "fade into the background" and left the other to take charge. He became quietly furious and carried out the tasks in an aloof and authoritarian manner.

One leader in the group was so supportive of group members that he interfered with his colleague's attempts to probe behind defenses. The group favored the supportive leader and the other one finally felt defeated and retreated.

Once a leader became involved in telling the group about painful introspective work he had done during the week relevant to his role in the group. It was inappropriate for him to indulge in this confession but his co-leader was moved by the poignancy of his colleague's suffering, which he was hearing for the first time, and felt protective and tender toward him.

Each co-therapist might have reacted differently. One might have good-naturedly done the administrative work; the next might have gotten angry openly; and the third might have stopped his partner. These alternatives suggest the question: How does each therapist affect the other? One approach to appraising intertherapist effects is to describe some important ingredients in the development of a good working relationship.

As co-therapists work together, they discover how each behaves in the group and the behaviors arouse a host of feelings. Whether these discoveries provoke criticism, anger, frustration, scorn, and sorrow or are ac-

cepted with understanding depends upon the maturity of the two part-
ners. As they become aware of their effects upon each other, they need to
develop a kind of mutuality whereby each learns how to deal with his
emotional reactions in the knowledge that his partner is sharing silently
in the process. Finally, as they proceed with their work, confidence must
develop that they are learning together to accommodate each to the
other as he is in the present and as he is "becoming."

Another requirement of a functioning co-therapy relationship is that
each therapist be open to an honest exchange of ideas about individual
group members and the movement of the group as a whole. The degree
of openness in each therapist is not a function only of his own psychic
organization but also of his partner's readiness to consider with respect
whatever he offers. Some therapists are stimulating to work with because
they are eager to explore all the possibilities the two workers can con-
ceive. If either therapist functions in a closed system, he dampens the
enthusiasm of his colleague and thereby interferes with the process of
giving to and taking from each other, which is the only means whereby
each can maintain a feeling of "aliveness" about his work and his rela-
tionship with his partner.

The "WE" Feeling

When two therapists decide to work together (or are required to as
in a training program), they enter the group initially as separate indi-
viduals regardless of how friendly they are with one another. As they
participate in and exchange views about the group, they begin to be
aware of special problems and to discuss ways of dealing with them. If a
healthy respect for each other exists, this joint activity eases them into the
first phase of a "we" feeling. This first phase may be expressed as, "Come
on, let's go. We're in this together, you know." Their focus is on the
problems in the group, and their attitude is one of mutual reassurance
that each is not alone. The next phase in developing the "we" feeling
evolves more gradually and almost imperceptibly as the two therapists
begin to appreciate each other's strengths and weaknesses and as they
"both" perceive the effect each one's interventions have on the group's
movement. In this phase a bond may develop which gives them the feel-
ing of sharing together in the group's progress. While the focus of their
activity is still on helping the group, added to their initial feeling of
joint responsibility can be feelings of pride and—yes—possessiveness. If

the therapists become friends, if they develop a rhythm in their work, there evolves a sense of "we-ness": as each therapist experiences the group he senses his partnership with his co-therapist. Finally, if they are able to develop this "we-ness," it reflects in their interaction in the group; feeling neither separation from one another nor an alliance with each other apart from the group, they interact openly and easily.

The question is posed again: How do co-therapists affect each other? The answers stem from two criteria against which all intertherapist events can be tested: (1) is each individual growing by virtue of the relationship? and (2) is the relationship between the co-therapists deepening in both emotional content and understanding?

WORKING TOGETHER IN THE GROUP

The Context of the Relationship

Since both leaders have contracted to help a group of patients, they may take it for granted that the group "comes first" and is all that "matters." They may assume that intertherapist interaction in the group will be minimal and characterized by objectivity, analytic comprehension, and good-humored acceptance. However, while there may be few "overt" intertherapist transactions in the group, "covert" transactions occur in varying degree whenever one therapist communicates verbally or nonverbally. Until their relationship is well established, the speaking therapist usually senses his partner's presence "as a colleague," wonders about the "rightness" of his repsonse in the eyes of his co-therapist, and hopes his co-therapist knows what he (the speaking therapist) "is doing." The listening therapist, in turn, may understand his partner's statements and concur, may be puzzled and struggle to pick up the meaning, may disagree and consider ways to change the direction of the group, or may become bored, annoyed, frustrated, etc. Sometimes a therapist communicates these thoughts and feelings to his co-therapist with gestures. At other times neither knows "where he is" relative to his partner. These intertherapist ties exist within the larger framework of therapist-to-member connections. Co-therapists, therefore, are faced with an intricate network of interactions: (1) each therapist to the other therapist, (2) each therapist to each member and to the group as a whole, (3) each therapist as "one partner of a couple" to each member and to the group as a whole, and (4) each member to the therapists and to other members.

This network of interactions may be symbolized as follows:

$$T_1 \longleftrightarrow T_2 \qquad\qquad\qquad\qquad M_{1 \cdot n} \longleftrightarrow M_{1 \cdot n}$$
$$T_1 \longleftrightarrow M_{1 \cdot n} \qquad T_2 \longleftrightarrow M_{1 \cdot n} \qquad M_{1 \cdot n} \longleftrightarrow G$$
$$T_1 \longleftrightarrow G \qquad T_2 \longleftrightarrow G$$
$$T_1(T_2) \longleftrightarrow M_{1 \cdot n} \quad T_2(T_1) \longleftrightarrow M_{1 \cdot n}$$
$$T_1(T_2) \longleftrightarrow G \qquad T_2(T_1) \longleftrightarrow G$$
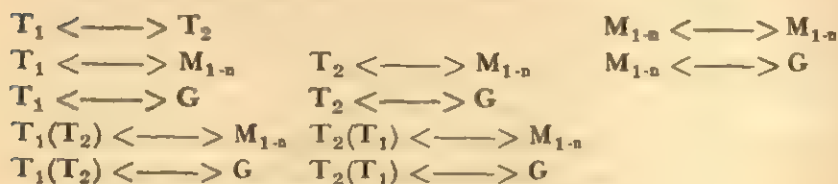
where:

$$T_1 = \text{Therapist \#1}$$
$$T_2 = \text{Therapist \#2}$$
$$M_{1 \cdot n} = \text{Each member in a group of n size}$$
$$T_1(T_2) = \text{Therapist \#1 as one partner in the couple}$$
$$T_2(T_1) = \text{Therapist \#2 as one partner in the couple}$$
$$G = \text{Group}$$
$$\longleftrightarrow = \text{Interacts}$$

When one imagines the behavioral content (thoughts, feelings, and overt acts) of these transactions, one begins to realize the complexities of the interaction potential in the group as well as the variety of choices each therapist has for useful interventions.

Loyalty

When one therapist engages the group, his partner is faced immediately with two decisions: (1) shall he support or disagree with the direction? and (2) how? A decision buttressed by a rationale, if one has time to reflect, is often complicated by a feeling of loyalty to both the group and to one's partner. Consider the following episodes:

Near the end of the fall semester before the leaders had considered the issue, a member asked if new members were going to be admitted in the spring. One leader, who felt strongly about letting in new members, began pressuring the group. At first they felt vague and restless, but as the leader pressed them with psychological and administrative reasons, they became antagonistic to both the idea and to the leader but were unable to express their feelings in order to resolve the issue. When the co-leader saw that the group was immobilized, he intervened with a comment about the pressure and the group's difficulty in dealing with it. The group rallied and finally decided it did not want new members.

Once a member sneeringly berated other members for doing a num-

ber of things: "sugar-coating" what they said, playing therapist with each other, etc. One of the leaders interrupted him and said he was getting angrier by the minute. Then he accused the member of not giving the group credit, of interfering with the group's movement, etc. Rather quickly, the co-leader stopped his colleague by asking the latter if he was disappointed. His reply of "yes" was followed by a heavy silence, which was broken when a member responded to the member who had been critical and the group followed.

During one session several members became angry at a leader whom they perceived had interrupted the group's discussion. As each person expressed his anger, he immediately redirected his energy toward someone else in the group. Within ten minutes seven or eight members were embroiled in a noisy confusion of anger and pain. By this time the leader who had been attacked was paralyzed with anxiety. He looked at the clock, which showed that only a few minutes remained in the hour, and pushed his chair back as though to stop the group action. His colleague was aware of the anxiety, yet persisted with the group a few minutes beyond the hour without reference to the initial target of the anger until the tension among the members had eased.

Each of these transaction units presents an engagement between therapists. In the first illustration the co-therapist does not offer his support; in the second, he literally stops his colleague; and in the third, overtly he ignores him. At first glance it may appear that the co-leader was loyal to the group. The first episode suggests this most clearly. In the second and third episodes it is more evident that he was loyal to both: he stopped the attack on the member but did not encourage the group to explore their reactions to his colleague; and he held his colleague to the anxiety-provoking scene, yet kept attention away from him.

Obviously other reactions were possible. In the last two incidents one might have suggested that the group explore their feelings toward his partner. But if it is clear that one's partner, at that moment, cannot handle the probable hostility and disappointment of the group, it is entirely conceivable that one will feel protective and will try to do something which has some therapeutic merit for the group even though it does not focus on the significant issue.

When, out of loyalty to the group and/or his partner, a co-therapist interferes with his colleague, he risks arousing a host of affective over-reactions in both himself and the other: self-doubt, apprehension, frustration, humiliation, anger, or gratitude. How a co-therapist's actions are experienced by the partner will depend, in part, upon the depth and

breadth of their relationship. To the extent that each partner knows that his colleague is aware of the partner's problems, the interventions can be acknowledged and accepted. Furthermore, the motive for the intervention is not misperceived: it is seen as loyalty. And, to complete the circular pattern, to the extent that each therapist perceives the form his partner's loyalty takes, he can function cooperatively as a co-leader.

Dependency and Independency

When co-leaders are involved with the group, though each must retain an independence of his colleague, he must also recognize his dependence upon him. His independence manifests itself in two ways: (1) if he is the main actor involved in the group's theme, he feels free to let his own feelings and thoughts prompt his actions; and (2) if his partner is the main actor he couples his awareness of the theme and his partner's role with an evaluation of their appropriateness to the movement of the group. Conversely, when one therapist is actively engaged with the group, he is dependent upon his partner to be alert enough to help both him and the group should they get off the track by redirecting attention to relevant content. Co-therapy does not permit one therapist to relax while the other works. On the contrary, co-therapy may demand more energy from therapists than a one-therapist group situation. In the latter the therapist does not run too great a risk of being criticized for inattentiveness or mistakes, but in a co-therapy situation, inattentiveness and errors become apparent. Another kind of dependency sometimes occurs in which one therapist is temporarily immobilized by anxiety, depression, etc., and needs the partner to carry the group. Hopefully, such human fallibility is accepted by both workers.

Dependency manifests itself in other ways. Each depends upon the "presence" of his colleague, and when one is absent, the other may feel varying degrees of aloneness and/or loneliness or panic. He may be acutely aware that there will be no one to re-live this experience with jointly afterwards, for even though one therapist tells his partner about the events which occurred, recounting the experience is not the same as reviewing it after having shared it together.

The Need for Gratification

Usually leaders are perceived differently by the group. Sometimes one is seen as aloof and intellectual while the other is seen as warm and

empathic. One may be seen as aggressive; the other, as supportive. Sometimes these perceptions are constant and held by the entire group; sometimes the perceptions vary with the history of the group and among the members. Probably the perceptions are accurate to some degree, for it is questionable whether two therapists of the same emotional organization and approaches to people are attracted to each other enough to want to work together.

The perceptions are accompanied by positive and negative feelings which may be reflected in a typology of the "good guy" and the "bad guy." As both leaders become aware of these group reactions, though each musters all his resources to remain in the detached role of the therapist, it is entirely possible that the "good guy" will feel pleased and the "bad guy" will feel hurt. Each therapist must then deal not only with his own feelings but also with those of his colleague.

Thus, co-therapists need to be in touch with their desire for gratification. If their individual needs are too great, competition develops for the respect and affection of the group, which makes it difficult for them to develop a plan for dealing with member transferences.

To guard against gratification needs is of particular importance in a co-therapy situation for two reasons: (1) group members attempt in a variety of subtle and not so subtle ways to separate the therapists; and (2) group reactions to each therapist are visible to both and therefore cannot be denied or ignored. Whether co-therapists deal together with these needs and how they deal with them depends upon their relationship.

Interventions by the Two Therapists

Interventions which co-therapists make generally determine the flow of the content in each group session. When therapists are compatible, the interventions of each are natural outgrowths of the material stimulated by the other, the rhythm in the group is smooth, and themes are resolved.

During an event in the group there are usually several aspects to which either therapist may respond and each therapist may be aware of all of these aspects. For example, consider the following situation:

A husband and wife who are participants in a group are encouraged to confront each other about what they want from each other. After they have spoken in abstract terms—"I want you to let me be myself"—the

wife is urged to be more specific. She begins to recount in detail a recent episode and is cut off in the middle by her husband who waves his hand and says summarily, "Yea, yea, okay, so get to the point." The wife stops, her face flushes, and tears come to her eyes.

A therapist may make one of at least four statements: (1) Let the tears and the feelings with them come. (2) What's behind the tears? (3) Why have you stopped your wife? and (4) I wonder if any of you in the group is reacting to Mary and John right now.

Which statement the therapist makes will stem from both his intellectual judgment and his emotional disposition at the moment he witnesses this event. In a long term, on-going, closed group, all of these levels of intervention are probably appropriate at some moment. But in a given moment, which one is best in light of the group's history, the degree of movement of the couple toward each other, and the intrapsychic state of the husband and wife presents an intricate problem. The only way co-therapists can resolve such a problem is by subjecting themselves to continual discussions meeting-by-meeting and agreeing upon a set of priorities.

While establishing priorities may be an intellectual matter of strategy and tactics, decisions regarding strategy and tactics are not simply an intellectual process. There are certain areas which one or both therapists may not be willing to tackle in the group. Or one therapist may say, "I think it is the thing to do because 'it feels right to me'," and no amount of intellectual probing can produce a rationale which satisfies both therapists. The two therapists, by a blending of their intellectual and emotional propensities, must find a common ground—both theoretical and operational—and learn to trust and be comfortable with their differences. This task is complicated by the increasing acceptance of numerous dimensions and techniques as efficacious for group work: analytic group psychotherapy, "here and now" existential group work, group dynamics principles, and specialized techniques such as Synanon "games," body movement therapy, psychodrama, etc.

When an intervention made by one therapist is considered inappropriate by the other, what actions are available to the partner? Co-therapists can agree, like parents, never to disagree in front of "the children." They can disagree openly but politely without any show of emotion. They can react in a tone which reveals whatever emotions they are experiencing. They can throw the issue to the group.

The first choice is detrimental to the group. If tension exists between co-therapists, members usually sense it and as a group react with an anxiety which inhibits movement. Furthermore, since members, in general, have developed defenses which help them avoid confronting and resolving disagreements between persons, it is beneficial to them to see that the two leaders can disagree and still like and respect one another and, in spite of their differences, want to continue to work together. Thus, disagreements between the leaders may serve as models for members to feel freer to be open in the group. However, this conclusion is clouded by several considerations.

When a therapist interferes with the direction his partner has set, he is signaling to his colleague, "I don't think what you said is appropriate to the movement in the group." Members, on the other hand, are encouraged to speak without reservations, initially at least, and only through participating in the group over a period of time do they learn what material is "appropriate" in terms of individual and group movement. The question arises whether, if one therapist "corrects" his colleague, will members perceive that they risk being "corrected" when they speak?

Another problem deals with the way in which therapists speak to each other. While there are undoubtedly moments when a therapist has strong emotional reactions to his partner's intervention, to the extent that he is relatively mature, he knows how to deal with his disagreement before the feelings become too strong or he is able to control the feelings. Thus, when one speaks to another, his tone is likely to sound matter of fact and unemotional. Members may assume, on the other hand, that strong feelings exist but conclude that the "proper" way to communicate them is in an evenly and mannerly fashion, a stance which they may then adopt for themselves. If, however, therapists express their feelings fully, the group may become paralyzed by anxiety.

In addition to interrupting one's colleague and the tone of the statement, there is the problem of the direction of the interruption. Consider the following example:

An older man in a group was struggling to talk with a young boy half his age. The boy was very kind and gentle. The man's first reactions were ones of restlessness, irritability, and a touch of anger. But as the boy continued patiently, the man's face began to flush and finally tears came to his eyes. Abruptly one leader intervened. "Jim, I don't under-

stand you. First you're angry and now you're about to cry. What's going on?" Jim immediately blocked.

The co-therapist had several alternatives: (1) to remain quiet; (2) to say, "Oh, Frank (the other therapist), I think Jim should just go ahead and let whatever feelings he is having come and tell us about them"; (3) to say, "Jim, what happened to your feelings?" or (4) to say, "I wonder how members in the group are reacting to what Frank just did?"

Probably as the two therapists get to know one another through their private conferences, they can work out a system agreeable to both for handling their disagreements. They may agree to let each one handle himself in any manner which comes spontaneously or they may work out various styles of "correcting" one another.

Another situation which is delicate for both the interpersonal relationship of the therapists and the movement of the group occurs when therapist A is actively engaged with the group while therapist B is passive. As long as material is flowing well, there is no need for therapist B to become involved. But suppose therapist A runs into a snag? Does therapist B bail him out? Sometimes a therapist becomes anxious if he is in a deadlock with the group; yet if each therapist always rescues his partner, it is possible that members will become dependent upon the therapists to do the same for them under all circumstances. Or if members notice that each therapist always helps his partner but does not always help the members, they may feel an alliance between the therapists which clearly defines their relationship as something entirely apart from the group's operation. If co-therapists are to tolerate a lack of help from each other at various times, a great deal of trust between them is necessary.

Conflict between Therapists[1]

The orthodox view of the therapist's role holds that he should bind his own needs and feelings and control those actions which might result if he expressed his impulses. If this model is adopted by co-therapists, conflicts between them are contained while in the group and are resolved outside, possibly with the aid of a consultant. Currently, however, prac-

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[1] Conflicts here refer to personality conflicts as opposed to the kind of disagreements discussed under *Interventions*.

tioners are scrutinizing this traditional model.[2] In both individual and group therapy, a question is being asked: How human may the therapist be while he is treating the patient? When co-therapists are working in a group, the question becomes: How human may the therapists be "as a couple?"

The first point to consider is what effect a confrontation between therapists has upon the group. If members expect co-therapists to engage with each other in ways similar to member-member interactions, the effect may be different than if therapist-therapist engagements occur unexpectedly. Second, If members witness inter-therapist conflicts, do the therapists lose their image as "experts" and as symbols of security? Third, Can co-therapists trust the group? If the two therapists agree to bring up the conflict in the group but do not then use what the members tell them, does this set the members back in their own development; i.e., is the disrespect which many of them felt from authority figures during early childhood reinforced? Finally, If the co-therapists put the matter to the group, can each depend upon his colleague to participate fully in the discussion? If one therapist withdraws, the conflict remains and is aggravated by the unsuccessful attempt at resolution.

In conclusion, co-therapists need to consider two points in determining the extent to which they bring their own conflicts to the group: (1) the emotional states of the members, and (2) the probable effects on the group of bringing up different kinds of conflicts; i.e., it may be useful to have the group help resolve some conflicts but devastating for it to try to deal with others.[3]

THE PRIVATE CONFERENCE

A conference should take place immediately after each group meeting while the reactions of the leaders are fresh. The discussion will be facilitated greatly if a tape recording of the meeting is available in order to prevent disagreements about what was said, when, by whom, and how.

A general principle determines the fruitfulness of these conferences:

[2] Dr. Richard Miller, of the University of Michigan, has described to the author a method of working which he and his partner have developed. He calls it "multiple therapy," a procedure whereby both therapists are as open in the group about their own conflicts as they expect members to be with each other.

[3] I believe the criterion of "effect" is more useful than one of "type" (neurotic, tactical) as proposed by Hulse et al. (1956).

the relationship is the vehicle for communicating the message. That is, the establishment of an emotional relationship between the two workers must take priority over their discussion of theoretical issues. Co-therapists may act on this principle in three ways: (1) by helping each other deal with feelings they are experiencing immediately following the group session; (2) by talking about the feelings they had toward one another during the group session; and (3) by recognizing and working with the emotional organization which determines each one's intellectual position.

Following a group session, it is not uncommon for one or both therapists to be excited, angry, sorrowful, depressed, dissatisfied, or exhausted. Earlier it was suggested that it is not a simple matter to determine where to direct one's loyalties while working in the group. During the private conference, however, loyalty should be directed clearly toward one's co-therapist. This does not mean that one cannot be critical of a partner's actions. It means criticism needs to be dealt with much as a therapist deals with it while working with a patient: in a manner which does not destroy the relationship between them. Following is an example:

During one session I arrived very late, and the group took no notice of my arrival. Soon, several members were talking about feeling outside the group and left out. They were verbalizing exactly my feeling so I said, "I'm feeling left out, too." Immediately, a number of members voiced angry statements (an accumulation of feelings from experiences we had had in earlier meetings). I became cold and hostile and took on the whole group. Throughout my co-therapist was silent. Finally, one member made a statement which permitted my partner to say, "Louise, is there anything you can do which will help Marilyn and others in here feel more a part of the group?" Louise got up, saying, "I think it would be better if we all sat in a circle inside the space created by the arrangement of these tables rather than all of us sitting behind the tables." (The room was a typical seminar classroom in which the tables were arranged in a horseshoe pattern). During the remaining few minutes of the session, the members expressed their greater comfort, and immediately following the meeting I felt elated because we had closed on a good note.

During our two-hour conference after the session my partner did not criticize my actions. He knew I was still tense and unaware of all the wrong things I had done and unable to talk about my behavior. We began speaking of the different kinds of strengths I had exhibited and how useful these strengths would be should I ever work with certain types of patients. It was his support which kept me from feeling guilty, inadequate, and angry with myself. Our relationship remained firm and

later I was able to analyze my behavior. Another time when I was tense following a meeting, he suggested casually that I record (we had no tape recorder for our sessions) verbatim all that had been said during a particularly painful exchange between me and a group member. By the time I had finished the recording, I was relaxed. Again, what I had done was inappropriate in the group, but our relationship was still solid and later we were able to discuss my actions.

It is difficult for either therapist to set aside his own feelings in order to help his colleague, and, of course, the question arises: who gets to speak first? If both therapists are over-reacting at the same time, they may need a consultant. The point is that no amount of discussion about theory and methods will be effective unless there is an emotional bond between the two therapists. By emotional bond, I mean a feeling that each respects and values the other as a human being and that each is aware of this feeling in the other.

It is common for the two therapists to devote their conference to an exploration of their involvements with particular members in the group (T $\longleftrightarrow$ M) and to discuss member involvements with other members (M $\longleftrightarrow$ M). If they restrict their discussion to these topics, however, plus the usual items of group progress and changes in individual members, they neglect what I consider a vital dimension of the group; namely, their feelings toward each other (T $\longleftrightarrow$ T). If they can discuss these feelings several things will happen. First, they will become aware of how each affects the other and thus avoid misinterpreting reactions to each other both in the group and during their conference. It is easy for a therapist to assume that his partner is impatient with certain interventions, and it is a relief to learn that he is wrong. On the other hand, if one therapist is angry during the session, it is important that this be cleared up in order that they may proceed. As one colleague said to me regarding her own co-therapist, "I just couldn't go into the next session without telling him how angry I was with him and getting it straightened out between us."

Second, each therapist can become aware of the other's strengths and weaknesses and each can know that the other knows. It is not enough that each therapist, from his observations of his partner, comes to know him. Ease and comfort in working with a partner comes about to the degree that each knows that the other knows him. As they are able to explore together areas in which each exhibits strengths or weaknesses,

it is possible for three things to occur: (1) each therapist can help his colleague become stronger and thereby more competent as a leader; (2) each can learn how to use his strengths to complement the other; and (3) each can learn to tolerate those intense moments when one must devote himself to the group even though he is aware that his partner is immobilized and his partner can learn to accept the choice his colleague makes because the material is useful to the group.

Third, each leader can grow as a person if both can establish the kind of relationship described. Perhaps this is another kind of loyalty. There is loyalty to the group and loyalty to one's partner in order to effect a good working relationship, but there is also a third kind: a commitment to oneself and to another person which involves helping both grow as human beings. If a therapist wants to use the opportunity a co-leadership experience offers not only to become a better therapist but to grow as a total person, it is only decent that he be generous enough (and strong enough) to help his partner to do the same.

When co-therapists talk with each other during their conference time, however, they must guard against looking upon it as a "therapy hour" during which intrapsychic phenomena are explored. That is, it is one thing for co-therapists to explore how they affect each other and how to become more effective as a working team, and quite another for them to discuss "why" they affect each other as they do. It does not help the working relationship for therapist A to know that certain of his behaviors remind therapist B of the latter's father. Better that such intrapsychic material be pursued with one's analyst.

Even if each therapist admits to neurotic reactions, there still remains the problem of learning to accommodate to each other, and rather quickly, for a practical reason: they must meet with their group today, tomorrow, and next week. Similarly, although both work through neurotic problems, they still face the task of learning to work together. One way to handle this requirement is to focus on the questions: What does and does not go on between us while we are in the group which helps or hinders progress? What can we do to become more competent as a team? Naturally, as the therapists answer these questions, each one will reveal many facets of his "inner being," and it is an exercise in judgment, tact, and kindness for each therapist to be unintrusive and respectful of that part of his partner's self which the latter chooses to keep private.

CONCLUSION

This paper focuses on the essence of the co-therapy situation: the relationship between the therapists. It delineates areas of contact between the therapists and specifies operationally those behaviors necessary to the development of trust, that quality considered by practitioners as essential to a good working relationship (Rabin, 1967). The discussion is offered in the spirit of Birdwhistell's (1963) statement regarding the teaching of group therapy: ". . . unless techniques are developed . . . the field will be restricted to 'natural' therapists who brilliantly perform therapeutic exercises which are non-repeatable by less gifted colleagues."

The model of intertherapist interaction presented here offers the opportunity for a deeply personal relationship. It demands a heavy investment of both time and energy and an emotional commitment which can be exhausting, rewarding, and fun.

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The Group Psychotherapy Literature 1968

Summarized by

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The year 1968 has been named by *The New York Times*, "the year of the group"; and indeed it would now be possible to spend every weekend, if not every night, of the year in some "encounter." Considerable concern is being expressed by many professionals about the cultish quality of much of this activity. Some feel that purposes are not adequately defined, that sufficient responsibility is not being accepted by the group leaders for the quality of the experience and the safeguarding of participants, and that the necessary skills and training which leaders should possess are inadequately defined. However, as Anthony (10) points out in his reflections on twenty years of group psychotherapy at the "Diamond" anniversary of the American Group Psychotherapy Association, maverick activity is generally experienced at the growing edges of a viable field and what today may seem way-out may in the future be incorporated on a more solid basis into the main body of accepted theory and practice. The major problem is to explore how experimentation and innovation can take place without undue risk to the subjects who participate and how minimal standards of safety can be enforced. While the professional literature does not yet fully reflect the ferment in the field caused by this proliferation of marathons, encounters, sensitivity training groups, use of nonverbal techniques, and sensory stimulation in attempts to intensify, speed up, or increase the immediacy of the group impact, it does indicate a wide diversity of viewpoints and approaches to group psychotherapy. Nina Toll (316) discusses a number of these new techniques in an interesting article.

Different time arrangements have become a focus of interest for group psychotherapists. Questions are being raised about whether it is more effective to have time-limited sessions or extended sessions and whether sessions should be grouped together in weekends, week-long institutes, or separated in the traditional once or twice a week arrangements. There are as yet no hard data. However, several experts discuss a paper by Stoller (307) on this subject (Spotnitz [302], Parloff [238], Bach [17], Anthony [9]) in the April issue of the *International Journal of Group Psychotherapy*. Lewis (186) examines the effect of nine-hour sessions on the participants' perceptions of themselves and others. Neto (225) and Weigel (335) both find no difference in reactions of participants in different arrangements. Mintz (216) describes phases in marathons: initial anxiety, moving through guilt to more intimate relationships with open expression of hostility and dependency, the need for love and the fear of rejection, to ultimate separation anxiety—a sequence which resembles that of any other type of group. In essence, whether groups last an hour or day or year, they tend to go through the same maneuvers of beginning, middle phase, and termination. The effect of fatigue and the sense of timelessness which the marathon provides as against the pressure of time-limited sessions are matters for consideration. Fagan et al. (89) describe three views of a marathon. Casriel and Deitch (48) and Kovan (169) point out that in marathons it is very important for the therapist to become a working member of the group and to be involved like other members. This raises the question, still in dispute, of the role of the leader. In analytic work, the therapist attempts to reduce to a minimum the arousal and expression of his emotional problems and countertransferences; Schwartz and Wolp (279) state that the therapist should be an interpreter; in existential work, the spontaneity and genuineness of the therapist in the encounter is seen as therapeutically important (Mullan, 221). A central question is how intrapsychic change actually takes place and whether the pressure cooker effect of intensity is important. Beukenkamp (29) addresses himself to this point. Day and Semrad (70), Berger (25), Foulkes (98), and Sapir (270) all examine differences between process groups and group psychotherapy. Fiebert (91) describes sensitivity training and Heath and Bacal (111) group psychotherapy as practiced at the Tavistock Clinic. Encounter groups are being utilized to extend the individual's capacity to be open and frank with others and to sustain a greater intensity and frequency of emotionality. Schwartz (280) and Mendell (212) address

themselves to this use of group interaction. Bindrim (30) asserts that nudity facilitates frankness and that physical contact can be enjoyed without sexual involvement. Gazda (106, 107) describes exercises for dealing with specific problems and for relaxing group members. Ingils (151) attempts to set some conditions for groups to be useful. Haer (130) examines the expression of anger in groups. Berne (27) and Wilson (339) discuss the applications of transactional analysis.

As predicted, there are increasingly frequent reports of the use of behavior conditioning in groups (Clement [55], Gazda [106, 107], Lieberman [188]. Solomon, et al. [300], Smith and Young [297], Truax [321], Blank [31], Carrera and Cohen [45], Paul [240]), and several authors find this method useful in the reduction of test anxiety with students (Cohen [57], Neuman [226], Suinn [309]). Kutash (172) and Abelson (1) both discuss the differences between education and therapy. Abelson concludes that the primary difference is in goal definition. Several writers are interested in the use of systems analysis in group treatment (Hicks [143], Laqueur [178]).

Scheidlinger (274) surveys the practice of group psychotherapy in the sixties, MacLennan and Levy (203) review the literature for 1967, and the Roche Reports continue to provide brief abstracts of presentations at professional meetings (60, 82, 97, 125, 144, 219, 229, 285, 290, 326).

METHODS AND TECHNIQUES

A number of papers deal with technical aspects of group management. Several authors describe the development of group programs and beginning groups. Solomon et al. (300) and Lieberman (188) discuss the values of groups for treatment. Greving et al. (122) describe group intake in an outpatient clinic. Haythorn (139) and Pollock (249) discuss patient selection. Kew (158) emphasizes the need for expertise on the part of those responsible for group programs. Gray (120) analyzes the influence of patient preparation on group functioning, Shelly and Stedry (287) the design of a group, and Sweeney and Drage (310) the initiation phase of group orientation. Paradise (237) discusses the factor of timing in the addition of new members.

Individual and group resistances continue to attract attention. Eisenberg and Abbott (84) describe the management of the monopolizer in the group. Lathrop (179) is concerned with acting out in supportive groups.

Ormont (231) relates group resistances to the group contract. Lindinger (191) discusses the termination of a resistance. Scheidlinger (272) examines the concept of regression as an intrinsic factor in all human groups, discusses the opportunities for working through in the group, and develops five categories of major group influence. Spotnitz (303) and Heigl-Evers et al. (142) are concerned with aggression in the group. Rosenthal (261) maintains that interpretation is secondary to the emotional reenactment of primary relationships in the group. Kadis and Winick (155) have an interesting discussion on fees in group therapy. Kirtley and Sacks (160) describe reactions to the death of a group member, and Ludwig and Marx (197) examine the strategies through which chronic schizophrenics deal with each other. Several therapists discuss aspects of the use of co-therapists (Brayboy and Marks [39], Lei et al. [175], Hays [138]).

Audio-Visual Materials

There is a growing interest in the use of videotape and closed circuit television for immediate feedback in group therapy, psychodrama, and training (Wilmer [338], Rogers [258], Vogeler and Greenberg [328], Goldfield and Levy [118], Finney [93], Danet [65], Czajkoski [64], Berger [26], Vinson [327]). Berzon (28) reports the use of taped programs for self-directed groups. Danet (66), Hurvitz (150) and Lubin (196) debate the effect on the viewing audience of a psychotherapy group led by Shostrom (288, 289) on commercial TV.

Milieu Setting: Community Mental Health

The use of professionals and nonprofessionals in mental health and in other human services, crisis management, and time-limited treatment seems to have become the hallmark of the community mental health approach due to the demand for more economical and effective use of manpower. The use of groups is essential to this field. Peck (243) emphasizes this point, and Scheidlinger (275) outlines a system for categorizing such groups and for teaching them through consultation. Macht et al. (199) also discuss consultation, and Gendlin (108) examines the relationship between psychotherapy and community psychology. Dellarossa (71) writes of the varieties of opportunities for training and research offered by groups in treatment centers. Sager (268) comments on the importance of groups in the reduction of alienation.

A relatively large number of papers report on the use of groups in

residential and partial hospitalization. Several papers describe the different kinds of groups, such as ward groups, group therapy, a variety of activity groups, groups with patients and families (Schwartz and Farmer [278], Thomson [313], Eddy et al. [81], Gralewicz et al. [119], Veltin [325], Healey [140], Kibel [159], Reid [252], Flegel [95], Weymouth and Taintor [337], Lipton et al. [194], Kutner [173], Richmond [254], Pullinger [251], Lentchner [183], Hoxworth and Alsup [148], Friedman [103]). Schwartz (280) did not attribute any significant changes to formal group therapy in milieu settings. Lipgar (192) reports dramatic changes in movement from back wards through group treatment. McGee et al. (210) compared a therapeutic milieu in which all parts of the program were integrated and conducted within a common philosophy with a routine program in which different approaches may co-exist, and found improvements in both settings. Howe (147) and Bedee (24) report on activities as useful therapeutic aids. Astrachan et al. (12) and Klagsbrun (285) both emphasize the importance of the compatibility of the group approach and the institutional philosophy. Kramer (171) reports using planned reinforcement by the counselors as part of the therapeutic milieu. Daniels and Rubin (67) studied all verbal communications and found patient participation positively correlated with treatment outcome. Berne (27) found staff meetings in the presence of patients to be enlightening for all. Martin (204) reports a didactic group which nurses can conduct without having to know enough dynamics to lead therapy groups. Budson and Christ (82) describe the evolution of drawing men out of back wards into "hall meetings" and from there into group therapy. Zinberg and Glotfelty (349) complain that the power of the peer group is insufficiently utilized in milieu therapy. Crary (61) outlines progressive goals in treatment. Denman and Ruffin (72) describe the role of the sociologists in milieu programs, and Polsky and Claster (250) have written a very interesting book on the dynamics of residential treatment.

Several papers relate to the transition of patients from the hospital to the community and to outpatient treatment of severely disturbed patients (Giordano et al. [115], Lipkin and Daniels [193], Christ and Goldstein [52], Seeman [282], Sadock et al. [266], Kramer [171]). Abrams (3), Amos and Gonzalez (7), and Baber (16) discuss foster care. Baber runs group meetings in the group foster homes but finds that there are typical problems of rivalry between social workers and foster parents. A similar observation has been made when boarding homes are used.

Several papers deal with the training of personnel and the roles of professionals and nonprofessionals in residential treatment. Ehrlich (83) describes the usefulness of group supervision of aides focusing on the understanding of process, and Abramczuk et al. (2) emphasize the importance of training psychologists and nurses in group psychotherapy. Batman and Binzley (20) held their classes for psychiatric aides on the wards to make them more concrete and relevant. Senay (284), in a day treatment program, encourages staff to examine their relationship to each other as well as to the patients.

The problems which are implicit in all these papers but which are not always clearly enunciated are: how to create a therapeutic milieu for severely disturbed patients in and out of the hospital; how to organize resources to assist patients to make the transition back into the community and rebuild their lives without getting lost in the process; how to achieve both continuity of care between hospital and community and still maintain a therapeutic milieu in the residential setting; to what extent the creation of a residential therapeutic milieu is compatible with the emphasis on speedily returning the patient to the community; how to train staff to behave therapeutically in a treatment milieu, and, perhaps most importantly, how the view of breakdown as an illness or as a dislocation of the system or as a cry for help affects treatment approach.

WORK WITH DIFFERENT AGE GROUPS

Although it is estimated that 10 percent of all children and youth are experiencing problems in social and psychological adjustment which could benefit from special attention and that 2 percent are severely disturbed, we still find that there are relatively few papers on the group treatment of children. Frank and Zilbach (102) report that an examination of the present position reveals that the field is in a chaotic state and that there is a need to adapt present knowledge to new demands. Scheidlinger (273), in assessing current trends, maintains that the community mental health center is stimulating a great expansion in the use of groups. MacLennan's experience has been that while there is very great interest in the use of groups both by mental health specialists and other similar service professionals and nonprofessionals, there is a paucity of personnel trained to understand group process and to work with children in groups. There also appears to be conflict in the minds of many professionals as

to whether it is preferable to work with parents and/or children, or with the family as a group. A second question is whether to work with the parents in their role as parents or as individuals with personal problems and tensions.

Most reports have been concerned with groups for children and/or parents suffering from special problems, such as brain-damaged children (Anderson [8]), foster children (Watson and Boverman [3*3]), socially retarded children (Mast [206], Landau [177]), for parents of children who are in hospitals (Patton et al. [239]), children with speech and hearing problems (Webster [334], Gregory [121]), pregnant adolescents (Braen et al. [38]). Several workers, however, report the use of behavior conditioning in children's groups (Carlin and Armstrong [44], Deskin [74], Clement [55]). Ritter (257) uses desensitization techniques in the treatment of phobias in children but does not concern himself with the question of whether the phobia is in fact expressing some one conflict which he does not touch. A few programs are discussed in which group therapy for children is included as part of a comprehensive therapeutic program of school recreation and parent/child treatment (Lilleskov et al. [189], Davis and Feinstein [69]). Aronowitz (11) examines the significance of games. Boulanger (37) reports discussion groups for children and adolescents. Winder and Tierney (341) discuss conjoint casework and group therapy for treatment of parents and children in crisis, and McCarthy et al. (207) report family life education groups for mothers of two-year olds and Glickman (117) with Headstart mothers. Rinn (256), examining selection of boys for activity group therapy, found that most judges had specific biases and based their opinions on descriptions of behavior rather than on clinical diagnosis.

The literature on groups for adolescents is much more lively. Kraft (170) has written an overview with an extensive bibliography. MacLennan and Felsenfeld (202) published a textbook on group counseling and psychotherapy with adolescents which examines the special issues and problems in working with this age group and favors approaches which capitalize on the adolescent's desire to cope more effectively and to reach a clearer understanding of his identity and role within normal, everyday settings. Elias (85) and Newton and Sovak (228) affirm the usefulness of group counseling as part of a therapeutic milieu in which work, play, and the living situation are all included in the treatment plan. Zouras

and Resnick (550) report a comprehensive summer program for under-achieving adolescents Gilliland (113) and Messano (213) agree that group counseling can be useful in the treatment of poorly motivated students, while Cheatham (51) did not find that it affected achievement Gilbreath (112) reports that strongly authoritative groups are most helpful to sub-missive constricted underachievers, whereas low authority groups assist the more spontaneous student to improve his grades Klapper and Todd (161) and Trefsen (318) report on groups in hospitals. O'Rourke and Chasens (232) and Miles (215) discuss the use of groups with unmarried mothers.

Ritter (257) describes group desensitization of phobias. Avery (14) conducts para-analytic group psychotherapy with blind adolescents. Stanley et al. (304) uses groups in the treatment of adolescent obesity Sarlin and Altshuler (271) to improve the communication of deaf students and Nash (224) as a medium for sex education in school. Several excellent papers have been written on multifamily group psychotherapy largely focusing on system analysis and family communication (Bowen and Gossett (78) Laqueur (188) Leichter and Schulman (181) Coughlin and Wimberger 59). Grunebaum and Christ (127) examine the effect of couples and family groups on the therapist.

There are surprisingly few papers on the group treatment of couples with marital problems although in many situations this may well be the treatment of choice Linden et al. (198) emphasize the opportunities in the group for examining value systems facilitating communication and reality testing. Everett (99) describes an adversary system in which the group members represent and portray the couple in conflict Blinder and Kirschenbaum (33) examine distortions in perception and communication and Deutman (79) comments on the similarities between spouses Burton and Kaplan (42) and Hanson et al. (133) discuss the group treatment of couples where one partner is alcoholic.

There are fewer reports of work with groups of college students this year although two interesting papers are concerned with this population (Thelen and Harris (312) Munzo and Aurachan (223)). There is only one paper dealing specifically with middle age (Halstead, 132) However groups for the elderly in and out of hospital and for working on specific problems appear popular. Schwartz and Papas (281), Nevruz (227) MacDonald (209), Yalom and Terrazas (346). However, Gunn (129) reports

that in one geriatric ward, groups, while they were informative for the staff, appeared to increase the patients' depression.

SPECIAL POPULATIONS

Addictions

Groups continue to be a choice form of treatment for alcoholism whether alone or combined with other therapies such as drug treatment and whether carried on by professionals or self-help groups (Fox and Lowe [101], Burton and Kaplan [42], Hanson et al. [133], Hartocollis and Sheafor [134], Kotis [168], Pokorny et al. [247], Soden [298], Tomsovic [317], Wolff [344]). Bolen (35) relates gambling to marital problems and prefers to work with couples' groups. There are several papers also on groups to combat obesity (Kornhaber [166], Stanley et al. [304], Wagonfeld and Wolowitz [329], Wine and Crumpton [342]) and on drug addiction (Klimenko [162], Levitt [185], Bassin [18]). The last paper deals with a program at Daytop Village and finds encounter and marathon groups effective in achieving behavioral change. Levitt (185), in a Mobilization for Youth camp program, found low-income youth reverted to the drug habit when they returned to the slums.

Crime and Delinquency

There were surprisingly few papers on the use of groups in corrections. Elias (85) discussed the work at Essexfields and Highfields. MacLennan and Felsenfeld (202) have a section in their book. Ostby (234) discusses working with prisoners and their families in and out of institutions. Sluga et al. (295) work with convicts in prison, and Knoblochava and Nezkusil (165) with prisoners on suspended sentence.

Sexual Problems

Most of the work undertaken on sexual problems, either heterosexual or homosexual, is not specially reported but is included in the normal course of many therapy groups. A small number of workers concentrate on certain "perversions" and consider special groups useful for these problems (Hadden [129], Resnik and Peters [253], Peters et al. [245], Witzig [343]). Leznenko (187) reports on a group method for the treatment of functional impotence in men.

Handicapped and Psychosomatic

Groups are becoming more popular in work with blind, deaf, and retarded patients, and patients with speech problems (Ross et al. [262], Browne et al. [41], Gregory [121], Landau [177], Webster [334], Ucer et al. [324], Cleland and Swartz [54], Halpern [131], Dial [76], Osherson [233]). Laeder et al. (174) and Sadoff and Collins (267) report considerable success with stutterers.

There seems to be renewed interest in the treatment of psychosomatic disorders in groups. Adsett et al. (4) report short-term groups for post-myocardial infarction patients and their wives. Enke (87) believes that capacity for social cooperation is important in psychosomatic problems. Frizzell (104) employs group therapy to reduce rebellion to dietary requirements in diabetes. Piskor and Paleos (246) use groups for patients who are recovering from a stroke and their wives.

The Socially Disadvantaged

Peck and Scheidlinger (244) review the various types of group interventions employed by professionals and nonprofessionals in work with poverty groups. Treger (319), Empey (86), and MacLennan (201) emphasize the importance of comprehensive planning and focus on reality in the treatment of people with many problems in their day-to-day living. Bloch (34) reports open-ended crisis management groups in order to achieve speedy relief of distress.

TRAINING

Several papers are concerned with the training of psychiatric residents in group psychotherapy and group dynamics (Gervais [110], Horwitz [145], Pauly and Saslow [241], Ruiz and Burgess [264], Millar et al. [214], Sadock et al. [265], Astrachan and Redlich [13], Battegay [21]). In spite of this interest, MacLennan and Zimmerman (mimeo), in a report to the American Group Psychotherapy Association, estimate that only about one-third of the residents' programs include any training in group psychotherapy, while two-thirds of clinical psychology and psychiatric nursing training and almost all social work schools include some experience with groups. McGee (208) discusses a variety of ways to supervise group psychotherapy. Todd and Pine (315) describe a method of peer group

supervision. Cristantiello (62) trains nursing faculty advisors in groups. Finney (93) describes group techniques for training psychotherapists. Hunter and Stern (149) train mental health workers; Brodsky (40) clergymen; Gifford (111), social workers; and Campbell and Dunnette (43), managers in group dynamics groups. House (146) reviews the literature in T-group education and leadership effectiveness. Several papers deal with the training of psychiatric aides to lead groups. A few are concerned with the use of observers for training and their effect on the group (Mackie and Wood [200], Cottle [58], Jarvis and Esty [153]). Kelly and Philbin (157) and Kneisl (163) report the use of sociodrama in training. Several writers on social work education express the need for broader examination of different group approaches (Yaillen [345], Overton [235], Glass [116], Tropp [320]).

RESEARCH

Research in group psychotherapy falls into several categories. The first is concerned with follow-up studies of outcome. Cullen (63) found favorable reactions to parent discussion groups. Pokorny et al. (247), in a study of 113 male alcoholics exposed to short-term inpatient treatment, report that 51 percent remained improved after one year. Levitt (185) followed up on young narcotic users and did not find treatment effective.

A second category of studies compares one method of treatment with another. Mezzano (213) reports that poorly motivated students in group counseling perform better than those in a control group. Thelen and Harris (312) find group counseling more effective than no counseling. Truax et al. (322) examined the effect of alternate sessions and vicarious therapy pretraining on group psychotherapy. They report that the latter is beneficial, the former retarding. Fleisher (96) examines selected and unselected groups in medical education. Bates (19) compares continuous sessions as against weekly group counseling and finds the latter appeared to be more useful. LeMay and Christensen (182) criticize the use of control groups. Some studies examine the effect of group participation on particular member attributes, such as ideal self concept (Truax et al., 323), dogmatism and conformity (Long, 195), the relationship between group position and achievement motivation (Zander and Forward, 347), the effect of group pressure on memory (Allen and Bragg, 5).

Several investigators study specific aspects of the group process, such

as decision-making (Clarkson, 53), verbal behavior in self-directed and therapist-led groups (Seligman, 283), a comparison of the accuracy of member and therapist's perceptions (Smith, 296), the reaction of group members to a member's termination (Zimmerman, 348), research conditions (Walton and McPherson, 330), the process of the group (Becker et al., 23), the influence of the leader on the level of the group, the relationship of behavior to group satisfaction (Gruen, 126).

A number of papers deal with a variety of group attributes, such as role allocation over time (Marwell, 205), the effect of group size (Gerard et al. [109], O'Dell [230]), seating arrangements (Ward, 332), interrelationships in groups as affected by group properties (Feldman, 90), factors related to group climates and group norms (Mudd [220], Moran and Klockars [218], Pollis and Montgomery [248]), group perceptions of members and nonmembers (Walum [331], Hashmi [135]).

Although there are many more reports of research on group treatment than in the past, there still remains a lack of coherence between goals, method, and outcome and a general uncertainty as to how to judge the quality of treatment or the effectiveness of therapists.

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Book Reviews

FREUD: POLITICAL AND SOCIAL THOUGHT. By *Paul Roazen.*
New York: Alfred A. Knopf, 1968. 322 pp., $6.95

This book stimulates a great deal of interest since the gap between
our understanding of individual human motivation and functioning and
the workings of political systems and large groups seems to become
deeper and wider in spite of our efforts to bridge it. The Freudian model
of individual human dynamics enables us to understand irrational mani-
festations and behavior, and applications of this understanding allows
us to work with patients in the direction of rationality. We have been
much less successful, however, in applying any model to the irrational
manifestations of societal behavior, as the ever-present multitude of po-
litical crises testify. The despair and helplessness which have given birth
to the various protest movements and popularized such escapist routes
as drug use and abuse have apparently stimulated others to a more thor-
ough search for solutions on a rational basis. The increasing interest in
combining the insights of psychoanalysis with the tenets of political the-
ory is an example, and this book is a contribution to this emerging field.

Unfortunately, this is a very uneven book. It contains many passages
in which psychological understanding is organically applied to political
phenomena but these are intertwined with long sections of irrelevant
material of little value to the subject of the book. Mr. Roazen, who is a
bright, young, political scientist with an excellent background in psycho-
analytic theory, a rare combination, is rather eager to demonstrate his
erudition. The reader is impressed by it but not necessarily made the
wiser, and the somewhat apologetic comments repeatedly testifying to
Freud's genius are superfluous and distractive.

Noting that "it is proper to speak of Freud's political psychology only in a very limited sense," the author admits with much candor that it is merely his own political interests that have led him to ferret out Freud's political comments. He further states that, "Politics never formed a very important part of his [Freud's] general intellectual concern." The author uses, therefore, psychoanalytic observations about the individual as tools for the understanding of group phenomena. He applies this to the fascinating examination of the reciprocal roles of leaders and of those who are led in democratic or totalitarian societies. This approach assumes that social and political organizations, being composed of individuals, can often best be understood by understanding the motivations and dynamics of the individuals who compose them. Thus, a leader in a totalitarian society is said to activate anxiety and unconscious feelings of guilt, and, indeed, his success is measured in terms of his ability to do so. When so applied, our understanding of the individual has a direct analogy to society as such, and possibly with only minor modifications is applicable to social and political processes. It obviates the need to examine and understand congregates of individuals as being separate and different in quality from the mere sum of the parts and minimizes the importance of group psychology. Thus, throughout the book the reader is faced in somewhat larger dimensions with the same problem that faces the group psychotherapist: does the group have a personality of its own, is it being treated, or do we deal basically with the individual although in a group framework?

Roazen makes an excellent attempt to examine the personality characteristics of the political leader but fails to develop this theme systematically. He makes other promising excursions, such as his examination of the distinctions between totalitarianism and democracy in terms of ego functions, but again the promise is left unfulfilled. The author's preoccupation with Freudiana repeatedly distracts him, and, consequently, in spite of his efforts, we still miss the full potential significance of psychoanalysis for the study of politics.

The three hundred and twenty-two pages of this book would have benefited at the hands of a good editor, but nevertheless they bring the reader a fascinating story. To a field so rich in opportunities yet so poor in objective, valid, scientific data, Roazen makes a timely and useful contribution. The book serves as a reminder of how much further work is needed, using the same scientific tools of old, namely, the direct observation of human nature in political process.

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USE OF INTERPRETATION IN TREATMENT: TECHNIQUE
AND ART. By *Emanuel F. Hammer*. New York: Grune & Stratton,
1968. 379 pp., $16.75

This is a compilation of forty-three articles on and about the use of
interpretation in treating emotionally disturbed persons. All of the au-
thors agree that interpretation is a major tool of the therapist but all find
it difficult to describe, to deal with, in specificity. Interpretation is not
synonymous with maturation, insight, change, cure, or with therapeutic
acts. It is simply interpretation, and, as William Snyder points out, it
represents less than one-fifth of the therapist's activity.

The shortage of systematic thinking about psychotherapy is nowhere
so evident as in the wide range of discussion and divergent definitions
assigned to that act of the therapist labeled "interpretation." Here again
we see the poverty of those therapies which are divorced from a psy-
chology, from a theory of man including normal psychological develop-
ment, psychopathological formations, dynamics of behavior, and the
bases for modification or change. Without such a theoretical framework,
it becomes increasingly difficult to describe a theory of therapeutics with-
in which concepts, such as interpretation, have specific meaning.

One of the many abuses heaped upon dynamic psychology arises out
of the misuse of constructs extrapolated from the organized body of psy-
choanalytic thinking and, without re-definition, misapplied in other con-
ceptual frames. Such has been the fate of technical terms such as re-
sistance, repression, transference, countertransference, acting out, and
now interpretation.

A most moderate psychoanalytic stance with regard to interpretation
is that it is a way in which the therapist points out relationships, similari-
ties and differences, and connections between the patient's past and
present, words and actions, inner and outer living, objective and subjec-
tive behavior with the purpose of increasing the person's consciousness,
his awareness of himself and of the other. It is thus more than merely
clarifying the symbolic meaning of behavior, which is interpretation in
its purest form. In this volume, interpretation is used very loosely, synony-
mous with telling, intervening, teaching, labeling, confronting, attacking,
challenging, feeding, uncovering, unmasking, clarifying, verbalizing,
stripping away, spontaneous emoting, and so on. It is too frequently re-
garded as any thoughtful procedure, verbalization, declaration, or state-
ment on the part of the therapist.

A large portion of this book deals with other aspects of human be-
havior including sociology, linguistics, anthropology, philosophy in gen-

eral, and their applications to persons, developmental psychology, the history and theory of psychotherapy, its goals, other techniques, cure, spontaneity, free association and dreams, insight, silence, the relationship between insight and change.

Reuben Fine's chapter is a good introduction to therapeutic technique and is closely related to the subject matter; it is recommended reading for all who are interested in the analytic position with regard to the meaning of interpretation. There is an excellent article by Jule Nydes, whose view of interpretation is that it is basically for reductionistic and generalization purposes. John Herma's chapter contributes to our understanding of the communications aspects of interpretation, including intention and reception. Many authors point out the importance of understanding interpretation not for itself but how the patient responds or reacts to it as the central focus of the therapeutic work. The article by Martin Bergmann is a magnificent analysis of the historical and methodological development of the use of interpretation in dreams. Harry Bone offers an excellent personal appraisal of Rogers and Ellis from the viewpoint of the philosophy of treatment, but his article is much too general and has little to do with interpretation as such. The Kleinian position is represented by Dorothy Bloch who emphasizes the infanticidal feelings as preceding the patricidal. Only one chapter is devoted to interpretation in group therapy; the others deal exclusively with patients in the individual setting. An interesting position is Erwin Singer's on the reluctance to interpret.

Perhaps it is because the authors did not restrict themselves to the area of interpretation that they, and the editor, deserve much credit for opening up many new doors of inquiry regarding various treatment modalities and treatment problems exclusive of interpretation in either a broad or narrow sense. It would have been easier to review this book had the editor called it "Some Exciting Ideas About Psychotherapy by Some Exciting Practitioners Who Have Something to Contribute to Our Thinking About Our Daily Work."

EMANUEL K. SCHWARTZ, Ph.D.
New York, New York

ROLES AND PARADIGMS IN PSYCHOTHERAPY. Edited by *Marie Coleman Nelson*. New York: Grune & Stratton, 1968. 373 pp., $13.75

A group of psychoanalytic therapists in collaboration with a sociologist-historian, all of them affiliated with the Natioanl Psychological Association of Psychoanalysis, have contributed papers to this provocative book. The editor, Marie Coleman Nelson, is a member of the group and a recognized leader in the paradigmatic approach.

Paradigmatic psychotherapy was born out of frustration with the patient who, with his poorly developed observing ego, was unresponsive to the interpretative focus of traditional psychoanalytic therapy and for whom one did not want to settle for supportive goals. The therapist "paradigms," i.e., shows by example, the patient's central intrapsychic conflict by assuming the role of the syntonic part of the conflict or siding with the resistance. For example, the therapist may role-play the helpless, irresponsible side of an infantile patient or the punitive superego of an overly responsible, self-condemning patient. Clinical applications with rich therapy protocols make up the largest part of this book.

Paradigmatic psychotherapy has its theoretical roots in psychoanalytic thinking and in American psychology and sociology, especially in relation to role conception; this is interestingly discussed in the first two chapters.

Concerning the theory of treatment, paradigmatic psychotherapy can be loosely classified with some of the innovative therapies, such as Jay Haley's *Strategies of Psychotherapy*, Victor Frankl's "paradoxical intention," or any of the growing number of experiential or action-oriented group and family therapies. In these therapies, interpretation is not a major technique; "gut reactions" are often directly elicited, and the therapist plays roles whose overt manifestations often seem paradoxical, if not sometimes "crazy," to the observer.

This book, which contains extensive references, is an important source of articles by people central to the paradigmatic approach. It is especially recommended to the serious student of psychotherapy who, when disturbed by innovative ideas, does not avoid but instead listens to his disturbing rumbles.

HERBERT M. RABIN, Ph.D.
New York, New York

Books Received

ELEMENTARY STATISTICS: ORGANIZED AND SIMPLIFIED. By *Helen Heath*. Springfield, Ill.: Charles C Thomas, 1968. ($8.75) 146 pp.

THE TREATMENT OF FAMILIES IN CRISIS. By *Donald G. Langsley* and *David M. Kaplan*. New York: Grune & Stratton, 1968. ($7.50) 184 pp.

SOCIAL SERVICES TO THE MENTALLY RETARDED By *Helen L. Beck*. Springfield, Ill.: Charles C Thomas, 1969. ($8.75) 207 pp.

THE SEEKERS. By *Jess Stearn*. Garden City: Doubleday, 1969. ($5.95) 384 pp.

ON SIGMUND FREUD'S DREAMS. By *Alexander Grinstein*. Detroit: Wayne State University Press, 1968. ($17.50) 476 pp.

DEAR DR. HIPPOCRATES. By *Eugene Schoenfeld*. New York: Grove Press, 1969. ($5.00) 112 pp.

POETRY THERAPY. By *Jack J. Leedy*. Philadelphia: J.B. Lippincott, 1969. ($7.00) 288 pp.

SOCIAL AND CULTURAL FOUNDATIONS OF GUIDANCE. Edited by *Esther M. Lloyd-Jones* and *Norah Rosenau*. New York: Holt, Rinehart & Winston, 1968. ($6.95) 643 pp.

A PSYCHOLOGICAL APPROACH TO ABNORMAL BEHAVIOR. By *Leonard P. Ullmann* and *Leonard Krasner*. Englewood Cliffs, N.J.: Prentice-Hall, 1969. ($9.95) 687 pp.

ANNUAL REVIEW OF PSYCHOLOGY, VOL. 20. Edited by *Paul H. Mussen* and *Mark R. Rosenzweig*. Palo Alto, Calif.: Annual Reviews, Inc., 1969. ($8.50 U.S.A., $9.00 Foreign) 516 pp.

THE TOKEN ECONOMY: A MOTIVATIONAL SYSTEM FOR THERAPY AND REHABILITATION. By *Teodoro Ayllon* and *Nathan Azrin*. New York: Appleton-Century-Crofts, 1968. ($3.95) 288 pp. (paperbound)

PSYCHOTHERAPY FROM THE CENTER: A HUMANISTIC VIEW OF CHANGE AND OF GROWTH. By *Rahe B. Corlis* and *Peter Rabe*. Scranton, Pa.: International Textbook, 1969. ($6.00) 131 pp.

COMMUNITIES IN DISASTER. By *Allen H. Barton*. New York: Doubleday, 1969. ($6.95) 352 pp.

THE PRISON OF MY MIND. By *Barbara Field Benziger*. New York: Walker and Co., 1969. ($4.95) 171 pp.

WHY PEOPLE GO TO PSYCHIATRISTS. By *Charles Kadushin*. New York: Atherton Press, 1969. ($8.95) 373 pp.

RORSCHACH WITH CHILDREN. By *Jessie Francis-Williams*. Headington Hill Hall, Oxford: Pergamon Press Ltd., 1969. ($7.00 hard cover, $4.75 paperbound) 169 pp.

DIFFERENTIAL DIAGNOSIS AND TREATMENT IN SOCIAL WORK. Edited by *Francis J. Turner*. New York: The Free Press, 1968. ($13.95) 644 pp.

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To Contributors

Manuscripts—Manuscripts submitted for publication should be sent to Dr. Harris B. Peck, International Journal of Group Psychotherapy, P.O. Box 230, 150 Christopher St., New York, N.Y. 10014. In general, the length of papers should be determined by the requirements of the content, but papers intended as Brief Communications should not exceed six typewritten pages. Manuscripts must be double-spaced type-written scripts on bond paper, with a 1½ inch margin on the left side. An original and one carbon copy should be submitted. All footnotes should be typed, double-spaced, at the bottom of relevant pages and should be numbered consecutively throughout. References should be given, *not* in footnotes, but in an alphabetical list at the end of the paper. In the text, citation of an author should be followed by the year of the publication in parentheses; for example, Slavson (1960). In the list of references, give last name of author, initials, year of publication, title, and for books, city and publisher; for journals, name of journal, volume number in Arabic numerals, and inclusive page numbers. Omit all underlining. For style sheets, write to International Universities Press. Author's professional affiliation should appear in a footnote on page one, his mailing address at the end of the paper following the references. The cost for bringing manuscripts into proper shape for the printer will be charged to the author, as will the cost for the publication of charts, tables, and pictures.

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Announcement

In the ten years since this editor assumed responsibility for the *International Journal of Group Psychotherapy*, the field of group psychotherapy and of related approaches has greatly expanded, the number of articles deserving careful review has increased, and the demands upon the editorial staff have grown accordingly. There are, in addition, such matters requiring attention as the introduction of invited symposia dealing with new and controversial areas in the field and intensified efforts to extend the international scope of the *Journal*.

To assist in carrying out these current and new functions, I am pleased to announce the appointment of Saul Scheidlinger, Ph.D., as Associate Editor. Dr. Scheidlinger has been one of the mainstays of the Editorial Committee of the *Journal* for more than ten years. His broad clinical experience as well as his extensive and scholarly interest in the field are well known, and his devotion to the work of the *Journal* has been outstanding.

Miss Jo Coudert, long in charge of the editing of manuscripts, has been appointed Managing Editor of the *Journal*, and Robert MacGregor, Ph D., and Clifford Sager, M D., are new members of the Editorial Committee.

I look forward to their help in maintaining and improving the quality of the *Journal*.

HARRIS B. PECK, M.D.
Editor

Acting In and the Therapeutic Contract in Group Psychoanalysis

LOUIS R. ORMONT, Ph.D.

When a patient enters group analysis, he makes a contract with the therapist to talk. He agrees to reveal his thoughts, feelings, drives, impulses, wishes, fantasies, and dreams. We, the therapists, agree to use this material to understand and make clear to him the meaningful story of his life. However, as the patient begins his task, he also begins to falter in his resolve and to deviate from the agreement. Soon he fails to do what he agreed to do. We study the way he fails and the reasons for his failure, and in the course of our study we find out how he sees the world and why he encounters difficulties (Ormont, 1962).

There are many ways a patient may break his contract. Instead of relating the emotionally significant story of his life in words, he may communicate it in action, dramatizing the story through his behavior in the group. Such behavior has been called *acting in*. Both Eidelberg (1968) and Zeligs (1967) claim to have introduced the term. Since 1957, Kohut (1957), Tarachow (1963), Greenson (1967), and others have refined it.

By now, the term has come to mean the re-enactment by the patient of his life history, albeit in a disguised fashion, within the therapeutic setting. Such re-enactments are compulsive and repetitive. The patient cannot recall the antecedent events giving rise to his behavior. And because his acting in gratifies a hidden wish, he is apt to defend it fiercely or rationalize it even though it appears patently inappropriate to other group members.

We may distinguish between verbal and physical acting in. Verbal

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acting in requires no bodily movements. For instance, a patient may experience group therapy as an arena in which he can indulge himself with abandon, and instead of talking about his feelings, he expresses them.

A lively actress would burst into a screaming tirade at the slightest provocation, assaulting group members with obscenities, invectives, and epithets. She would dredge up lists of stored-up defects of an offending member, not deigning to describe what she felt about these failings or why she felt this way. Once, when asked about her feelings, she retorted, "My feelings show in my voice and on my face, and if you can't read them there, t. s.!" Only when finally threatened with expulsion from the group did she take hold of herself and become receptive to exploring her behavior.

Physical acting in is more serious and often even more difficult to deal with.

About once a month, Carl, a usually talkative sculptor, would arrive ten minutes early, carrying his most recent drawings and clay models which he would carefully place under his chair. Through most of the session he would sit quietly and contentedly, seemingly preoccupied with himself. Then, shortly before the end of the meeting, he would shyly announce that he had been working on a project that week. After that, he would stand up, pull out his sketches and clay models, make a statement about each and pass it around.

He would beam at any member who approved of his work, but if one did not respond, he would stare at him and scowl. In each session following a presentation of his work, Carl's behavior would be different. To members who had not responded to his work on the previous week, he would make caustic comments, while to those who had been responsive, he would give of himself generously, even coming to their defense when it was unnecessary.

Carl was caught in an acting-in pattern. Though he did not know it at the time, he was responding to a compulsive need to gratify himself. Instead of recounting an isolated segment of his past in words, he was reproducing a total experience in action.

Carl had no interest in understanding why he brought his productions to the group meetings or why he tucked them under his chair. He brushed aside whatever the analyst said about his behavior and he regularly distracted the group members from analytically pursuing the matter, either by rationalizing the details of his actions or by praising the members for showing genuine interest in his work and career.

To Carl, discussing his acting-in behavior was dangerous. The more he knew about it, the harder it would be for him to continue it; and he very much wanted to go on bringing in his artistic work. He enjoyed the group's admiration, found it rewarding and stimulating, and did not want to lose it.

But this behavior blocked his therapeutic progress. He was buying admiration at great expense: he would reveal nothing of his dreams, thoughts, wishes or social life; and in order to limit attention to his art, he would tell the group nothing of his deteriorating marriage or of his abrasive conflicts with his superiors. He would not even say where he taught, nor was he interested in establishing any relationship except that of being admired and admiring his admirers in return.

Carl was not unusual. We frequently see patients who restrict their whole range of possible responses by a single compulsive act. Though we can learn much about the patient by studying this act, this is not our primary goal. We are more interested in helping him convert his penchant to act into a wish to talk, a far more desirable and maturational activity. To do this, we must analyze the acting in, uncover its historical roots, and resolve the tendency to engage in it.

The analyst approached Carl's pattern by analyzing the group's response to it. Once he resolved the members' resistance to confronting the sculptor with his behavior, they began to thwart Carl's activity at every turn, breaking in and questioning each detail. After much analytic labor, the genesis of Carl's acting in emerged. He was repeating his early toilet-training traumas—his chair being a symbolic toilet, his productions being symbolic fecal gifts—and he was recapitulating an intense struggle with a mother who swung unpredictably from approval to disapproval of his actions. His behavior in the group was an expression of his old unfulfilled wish for unqualified acceptance by his mother, whom the group now represented. The analyst, representing his father, was of minimal importance in this early drama.

As the work with Carl might suggest, acting in calls for much therapeutic effort. Often, before we can trace the origin of such behavior and resolve it, we must shore up the patient's ego, develop a cooperative frame of mind in him, and help him come to see his own acting in objectively, as alien and bizarre.

Difficult as it is to resolve acting in in individual therapy, it is doubly so in group analysis. For one thing, the group analyst has less control of

the stimuli to which his patient is subjected than does the individual analyst. Group members who are predisposed to acting in may take the slightest hint from another member as a cue to act. Many an actor in has a near-zero tolerance for guilt, frustration, or anxiety. In group, intense emotional interchanges can unsettle the foundations of a wobbly ego, foundations which a skilled individual therapist would have approached only later in the treatment. This unsettling can propel an actor in into activity to restore his psychic equilibrium. And when the actor in is acutely anxious, it may be difficult to get him to sit still long enough to examine what he is doing. His self-restraining mechanisms fail him, and his sense of reality is frequently disturbed. This makes it difficult to show him connections between what he is experiencing and the events in his life at the moment.

One young man would spring to his feet and make a beeline for the bathroom at the mention of sex. Though this occurred repeatedly, it took the combined efforts of the analyst and the whole group to convince him there was a connection between the subject matter and his urges. All he experienced was a need to urinate.

Even when the patient who acts in has excellent insight into his behavior, the insight may have no effect on his actions. A perceptive, 49-year-old architect, who had had some nine years of individual analysis, could not desist from opening a window to let out a "foul thought" uttered by a group member or closing a window to keep out a tempting but unacceptable one uttered by another member. He knew the dynamics and the relevant historical facts and had discussed them with the group, but knowledge of the facts was not enough to help him control his compulsion. He argued vehemently that he had to be comfortable or he could not listen or function, even though his actions were highly provocative to the group. On cold days other members would spring up to shut the opened windows. This would start violent quarrels which would continue for as long as five minutes, creating uproar and confusion.

In short, persistent and unchecked acting in by even a single member may disrupt and demoralize a whole group, sometimes bringing its progress to a creaking, if not disastrous, halt.

A timid postal clerk would shake in terror and stammer incoherently each time an 18-year-old boy reached for his switchblade. The boy felt he had to open and close the knife as a magical gesture to ward off a

potential adversary. The group therapist, because of his own difficulties, paid inadequate attention to the boy's ritual. Not only did the timid postal clerk leave after three sessions, but over a period of eight weeks the membership of the group dropped from ten to four. The dropouts had identified with the boy who was acting in: they felt they too were on the verge of losing control and acting irrationally, and they protected themselves from their own impulses by withdrawing from the threatening situation.

Some therapists deal with the problem of acting in by the simple expedient of a careful intake screening. They look for impulse-ridden incidents in the prospect's background. Should these appear to be part of a life pattern, another approach may be the treatment of choice for the prospect.

During a screening interview, a brawny physical education instructor revealed that he would "get wound up tight" during the day and would find release at night by making the rounds of the local bars to pick a fight. He loved to smash "pasty-faced" men in the nose. Subsequent probing uncovered a long history of uncontrolled spurts of physical violence in his family. The group analyst felt that the prospect's anxiety could be better managed in individual treatment.

But even a thorough screening interview may not enable a therapist to spot a very inhibited person with latent impulsiveness.

A restrained businessman in his late forties presented nothing in his background on initial contact that would indicate potential difficulty, except a vague suggestion of a long adolescent conflict with his father. Accepted for group therapy, at first he seemed to function well in the group and benefit from it. But as the transference intensified, his conflict with authority proved too much for him. He could not stop belittling and negatively imitating the analyst, and would sometimes even sit in the analyst's chair and start the session before the analyst entered. Finally, he tried to manipulate the group to meet without the analyst, to get rid of him. His inflammatory tactics created so much havoc that the analyst was forced to terminate treatment. The patient interpreted this as a victory. He had won. He had not been subdued.

Such activity is not unusual, even though in this instance it was especially intense and intractable. If the therapist has permitted transference relationships to develop within the group—and hopefully he has—each and every member will at one time or another regress to an

earlier phase of development, often to the preverbal level, a time when action was the only language. Faced with all these entrenched resistances, how can the therapist enlist the patients' reasonable egos on his side, get them to help him to uncover and work through their memories and feelings in words? First, he can lay the groundwork of group therapy in such a way as to minimize acting in. That is, he can firmly establish the analytic contract at the outset, letting the members know, in no uncertain terms, what is and what is not expected of them. In brief, he expects them to come on time, pay their bills on time, preserve the group confidentiality, and restrict their activities to verbal communication (Ormont, 1962).

He does this by bringing the first sign of acting in to the member's attention. For example, if Eddie reaches for Jane's hand and holds it in a gesture of friendship, the therapist says, "Eddie, you're supposed to put your thoughts and feelings into words. When you touch Jane, you break the contract." The idea that members are expected to inhibit their actions in favor of talk is pointed up again and again, at the time of the action, but for the most part, it is well not to offer interpretations of acting in during this educational phase; we are interested only in developing a lively concern in our working agreement and in spelling out its terms. Our opening statement of ground rules goes a long way toward reducing nonverbal communication. It also gives the members a language, an attitude, and the tools for use with fellow members who later make gestures toward acting in. Great therapeutic leverage is gained by pointing out the behavior at the beginning of the group experience.

Once the contractual agreement is spelled out, the analyst begins to make direct transference interpretations of deviant activity.

A prim seamstress had a tendency to brush lint off her lap each time she was addressed by an aggressively amorous salesman. When the analyst observed she was "brushing the man off" instead of putting her thoughts into language, she was freed to change her actions into words. She launched into a scathing description of the salesman's brashness.

Behavior is interpreted to the group members in the direction of who is doing what to whom. Members quickly grasp this object-oriented approach (Spotnitz, 1968), and they become uncannily insightful with on-the-spot interpretations of acting in, detecting it in the subtlest

interactions. What one member overlooks, another sees with penetrating clarity. Once a member reveals the hidden agenda behind another member's activity, the submerged feelings surface, and we are brought closer to the meaningful story of his life.

Acting in is more often than not an expression of smoldering but unverbalized resentment. The analyst must be ever on the alert for telltale signs of this.

Whenever a sensitive musician felt overlooked by the analyst, he withdrew from the emotional current in the group. He would annoyingly drum his fingers on the arms of his chair, seemingly engrossed in studying the pictures on the wall. The analyst asked a withdrawn girl why the group ignored the drummer and his picture-gazing; whereupon the man sprang to his feet, stabbed an accusing finger at the analyst, and shouted that it wasn't the members who were ignoring him, it was the analyst. The patient then poured out a passionate complaint that the analyst played favorites. Once he had released his resentment in words, the group was alerted to his pattern, and he became amenable to examining his primitive way of communicating resentment.

To make clear to the group members that dealing with acting in is the responsibility of the group as a whole, the analyst always asks the observing members why they are ignoring this or that acting in or what they make of the acting in under discussion. As soon as the group assumes the responsibility of confronting the actor in, we are able to take a different tack. If the members ignore any incipient acting in, we place their oversight first on our agenda. Why aren't they doing their job? What attitude do they share about the member or his conduct that neutralizes their willingness to examine the deviant behavior? For this exploration, we usually select a specific member who has a stake in the aberrant activity. His stake may be a meaningful relationship with the person engaging in it, a fear of the behavior, or a recognition that he too engages in that behavior or is capable of it. Such a member can often shed much light on the prevailing mood or attitude.

For months, one group member, a recent enthusiast of photography, dwelt on how enlightening and beneficial it would be if he took photographs of the members while the group meeting was going on. A few members supported him and the rest ignored the suggestion, but no one examined what he said. One day he unexpectedly arrived with his camera and began to take flash pictures. No one took exception. In fact, several

members seemed to stop what they were saying so he could get a better shot. After a few flashes, the analyst asked a shy woman who turned away every time the camera focused on her what she thought of the proceedings. She turned on the analyst for allowing the group session to deteriorate into a "peep show." Almost immediately another member chimed in that the group contract called for meaningful talk only. Several now chorused in agreement, and one asked why they were permitting the picture-taking. Soon the entire group was discussing the photographer's voyeurism and, on the heels of this, their own passive exhibitionistic tendencies. Instead of confronting the actor in, the analyst profitably dealt with the group's resistance by questioning an openly dissenting member. By eliciting her intense emotional response, he stimulated the others to examine how they had aided and abetted the acting in (Ormont, 1968).

From the group's point of view, the historical roots of a member's behavior are of secondary importance. An examination of the here-and-now almost invariably precedes analysis of the content or origins of a member's activity. The question, "Why is he acting this way today?" should take precedence over any search for unconscious patterns or unraveling of characterological motives and dynamics. In fact, such probing, if premature, may spark acting in. Hasty exploration of early damaging experiences may activate a complex train of psychic responses and catapult a member with shaky impulse control into destructive or self-destructive behavior.

A man, who had been sober for two years with the help of Alcoholics Anonymous, was accepted into a group. The members, and even the analyst, were captivated by his charm, and he was allowed to ramble on unchecked in the first session about his colorful, tempestuous life. The group was soon offering interpretations about his early traumatic experiences with an exploitive mother and a brutal, indifferent father. The next session he arrived intoxicated.

Instead of centering their attention on the man's interchanges with them in the immediate group setting, the members had been seduced by his manner into feeding him charged insights at a faster rate than he could digest them. The more conservative approach—"What's going on now?"—would have tended to solidify his ego by clarifying for him the details of his present motivations. With a firmer ego, he would perhaps have been able to restrict himself to the mediated response of talking and have avoided the more cryptic and regressive language of action.

Most decrees against acting in are undesirable. However, the therapist may at times be compelled to take stringent steps to preserve a group's effective functioning, and sometimes he may have to take urgent measures to protect the physical surroundings and property—let alone his patients.

When one woman impetuously picked up a table lamp and prepared to throw it at a terrified member, her analyst asked her why she was forcing him to terminate her therapy. Did she think a moment's gratification was worth it? When she put the lamp down, the analyst doggedly pursued this line of reasoning, asking her which she considered more critical: her feelings toward the whole group or her momentary rage at a single member. Still in a fury, she collapsed into tears. After a respectful silence the group began to explore her tendency to act on her violently aggressive impulses.

Basically, the therapist had addressed himself to her reasonable ego, presenting the problem as a matter of choosing between two alternatives. The assumption that she could control herself if she wanted to was implicit in his question, and after a thorough exploration of the incident she began to demonstrate more control over her impulses.

When a patient who is temporarily incapable of using his reasoning powers makes an aggressive physical move toward another, the act must be interrupted. The therapist must spell out for him as forcefully as possible the potential effects of his acting in. It is inexcusable not to take a strong stand in the face of a threat of physical damage.

An analyst kept saying to a group member who approached another threateningly with an ashtray in his hand, "You really don't want to do that. What you are acting out is an unconscious pattern. You are merely expressing your rage toward your father." It was a poor time to engage in analysis: the hapless victim had to be rushed to the hospital with a broken nose.

Whenever a member mentions an act that involves potential physical violence, as, for instance, when he says he would like to kick another in the stomach, he must be asked why he thinks that such an act—rather than talk, feeling, and insight—will solve his problems? What feeling is he really talking about?

One woman, when irritated, kept telling another that she would like to pull her hair out. The statement was not treated seriously. One day

she changed her verbal acting in to physical acting in and grabbed a fistful of hair. Both she and the victim had to be switched to different groups.

Ideally, a sophisticated group can deal with acting in with little or no help from the analyst, but sometimes, particularly in beginning groups, the burden falls on the analyst alone. Then nothing must be allowed to interfere with his single-minded attack on the problem, even if he must indicate that the situation is hopeless and that termination must be considered.

Even seemingly innocuous acting in calls for restraint when a member persistently and obdurately engages in it. Unless such a patient learns to hold himself in check, he is unlikely to produce therapeutically significant material or enter into meaningful interchanges, and this may make it difficult, if not impossible, to resolve his problems.

For months, one girl sat through each group meeting with a coat or sweater over her shoulders. She claimed she was too cold or uncomfortable otherwise. But her emotional interchanges were shallow and the material she revealed seemed trivial. When spoken to, she would invariably pull her garment tighter about her. One day the analyst asked one member why the group ignored her dress. The members developed a sudden interest in her attire, viewing it as armor. Once her pattern was elucidated, she revealed herself as a frightened though volatile person who felt she had no insulating skin barrier and would inwardly cringe when addressed by another. At last her therapy began to move.

A readiness to use meaningful words instead of action for communication is a mark of mature ego growth in psychoanalytic therapy. Only with sufficient verbalization can there be adequate ego development. Our primary task with acting in is to convert a tendency to act into a desire to talk.

Not until the positive transference is quite strong should the analyst consider adopting a forthrightly prohibitive role. Proscriptions made prematurely can result in a power struggle leading to a therapeutic stalemate. Circumspection and caution are needed, particularly in group analysis, for if clumsily handled, the decision to set limits may dress the group analyst in the robes of a moral judge, not only in the eyes of the actor in but also in those of the other members of the group as well. The analyst must remember that even to caution some members may sometimes be to belittle others.

If we read the evidence presented by our patients correctly, acting in has a number of distinctive characteristics:

There is a tendency to re-enact a past event in disguise, often events traumatic in the early years of the member's life. In Carl's case the events were toilet-training traumas. The actor in seems unable to recall the original event. In fact, his very act is a defense against recall, concealing the unremembered past. As long as Carl was allowed to go through his charade unchallenged, he had no early memories.

There is a tendency to reproduce a total historical experience rather than any select segment of it. In each session, in one way or another, the businessman acted in his hostility toward his father, using the analyst as the scapegoat.

There is a need to play out the drama with almost anyone, unlike the usual irrational transference attitude which attaches itself to significant people in the patient's life. It made no difference to the architect who was affected; he had to open and close the windows as a reaction to the thoughts uttered by others.

The acts of an actor in are entrenched, well-established, organized, and cohesive patterns. The action appears to be consciously willed. This is because the patient rationalizes every detail of it. The sculptor said he placed his clay models under his chair because they would be out of harm's way there. It all seemed perfectly logical to him.

The patient sees no need, and consequently has no desire, to learn anything new or different. Only the threat of terminating her treatment forced the actress to examine her vituperative attacks on others.

Embedded in the action is a wish that the patient could not act upon originally. The original event is repeated but skewed in the direction of being more fulfilling and less noxious. Carl yearned for the acceptance of his work by the entire group.

The actor in has an intense emotional stake in completing his act. Once it is finished, he derives great gratification from it.

He has a need to dramatize his activity and sometimes to seek out an unconsciously willing accomplice to participate in the drama. The photographer made fast friends with those who supported his suggestion that he take snapshots. These supporters were the very persons who appeared to pose for him when he took his flash pictures.

The act has considerable social value for both the actor in and the participants. Carl's career was helped and enhanced by the group's sup-

port, and many members got vicarious gratification from watching each phase of his artistic development, though he was making a shambles of the rest of his life.

The actor in tends to engage in magical thinking. He believes he need only make an act appear real in order to have it be real. Often he tends to experience his act as a magical way of warding off imagined danger. The 18-year-old boy got rid of not only his opponents but his fear with a flick of his switchblade.

Acting in presents the ultimate challenge to the group analyst. When confronted with it, his technique and ability are put to the test. So is his capacity to handle his own countertransference resistances, which acting in strongly elicits.

The handling and analysis of acting in takes considerable therapeutic judgment. Wherever possible, the analyst must make the member aware that he has a choice regarding his acting in. The choice is between the gratifications provided by the aberrant activity and the insight and development which could be provided by stemming it and resolving the tendency. Without instilling such awareness the analyst cannot hope to foster the growth of an autonomous ego and the sense of dignity that goes with it.

SUMMARY

Acting in is a form of acting out within the therapeutic setting. It is compulsive, repetitive, and ego-syntonic. The actor in engages in magical thinking and rationalizes the details of his behavior. He seeks fulfillment of his unfulfilled wishes, re-enacting his past but unable to recall it.

The group analyst can bring to bear a number of specific techniques on the problem to resolve this deviant tendency.

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Videotape Playback as a Therapeutic Device in Group Psychotherapy

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Psychotherapists have added to their armamentarium in the past decade a useful tool: the videorecorder. By videotaping therapy sessions, the therapist has a convenient, immediate, practical (after the initial expense) means of confronting patients with their own image and behavior. In a recent review article, a number of studies dealing with the use of videotape playback in the treatment of individuals and groups were described (Danet, 1968). There it was concluded that:

> In the group psychotherapy context, audiovisual feedback allows each member to view himself through his own eyes just as others in the group view him. . . . With videotape, a member can now *review* the reactions of others to his own behavior one or more times as necessary or desired. Perhaps of even greater significance, the individual now can have direct access to viewing what his own behavior actually was. In addition to being provided with the traditional source of feedback within the group itself, there is added a direct confrontation for the patient of his own image. He can place himself in the role of *reactor* to his own behavior, along with other group members and therapist(s) [p. 255].

The advantages of videotape feedback include the following: (1) playback is immediately available without any delay such as for film processing; (2) portions of particular significance may be replayed at the request

of members or therapists; (3) the group has access to material which otherwise rapidly fades into inaccurate memory; and (4) continuity between successive sessions can be provided when television feedback from the previous meeting is viewed.

The present paper will attempt to evaluate clinically the impact of videotape playback on two psychotherapy groups which were part of an experimental study described elsewhere (Danet, 1969). In this study, two university student groups from the Mental Hygiene Clinic of the University of Minnesota Health Service were videorecorded under identical conditions. The experimental group (E) received ten minutes of playback from the previous week at the beginning of each session (from the second through tenth meetings). The control group (C), in contrast, did not receive playback but was videorecorded with the knowledge that after the study ended they would be able to view one of their tapes. Playback in E consisted of a ten-minute segment fom the end of the previous meeting.

COMPOSITION OF THE GROUPS

Both groups contained seven students, four men and three women in C, and three men and four women in E. The same male and female therapists served as cotherapists in each group.[1] Group members fell into the categories of neurotic, mild to severe; character neurotic; and character disorder. Specific diagnoses were not available since clinic policy precluded formal labeling.

For purposes of this paper three questions will be considered as a means of evaluating the impact of videotape playback, or its absence, on both groups. First, the nature of the groups as they resembled and differed from other similar groups in the clinic will be described. Second, the question will be raised regarding the influence of the equipment and the videotaping procedures on the groups' functioning. Third, a study will be made of E group members' (therapists included) reactions to the playback experience.

The following information was obtained as a means of facilitating a clinical evaluation of the groups: (1) a record of attendance; (2) observations of the groups by therapists, members, or the writer; (3) ques-

tions asked of the members regarding prior acquaintance with one another before joining group and regarding extragroup socializing during the course of therapy; and (4) focused interviews with therapists and students. At the end of ten meetings, all but one of the members came to the clinic for a half-hour intensive depth interview conducted by the writer. Following Merton and Kendall (1946), the purpose of the interview was to obtain in detail subjective reactions to the group experience and, in particular, to the self-confrontation afforded by videotape feedback. Similar interviews with the therapists were aimed at discovering their clinical impressions of members' reactions as well as their own.

DESCRIPTION OF THE GROUPS

Group members were unusually committed to the therapy process, as reflected in the better than average attendance in both groups when compared to others in the clinic. In the first ten meetings, only one absence occurred in C. Although some members were occasionally absent in E, their record was nevertheless better than other groups. It was the observation of both therapists that the students showed an unusual degree of involvement, perhaps because they had accepted the responsibility of becoming part of a study. The therapists also observed that members tended to become more involved with one another more quickly than is typical. They were impressed by the early establishment of group cohesiveness.

The therapists were struck by the explosiveness and emotionality of E as compared to other groups in the clinic. Whereas C did not appear much different in this respect, E was unusual in the extent to which explosive material appeared. In this group's early sessions, it became apparent that the men were perceived as hostile, threatening individuals, especially in their treatment of women. Since five of six absences were women, possibly one reaction to the hostility expressed was for the women to absent themselves. At least one girl approached a therapist with the desire to leave the group. After the tenth meeting two did terminate.

Questionnaire responses revealed that both groups contained members who were without any significant prior acquaintance. Answers to the item inquiring about extragroup contact during therapy showed

that considerably more occurred in E. All reported some form of association, from casual conversation to dating, while in C half as many encounters were mentioned, and these were of a more superficial nature than those reported by E members. One explanation for this difference between the groups was that the amount of anger and hostility expressed in E produced a strong need for the expression of some positive feeling outside the group. Such socializing could have dampened some of the hostile atmosphere that prevailed inside the group.

INFLUENCE OF VIDEOTAPING PROCEDURES ON THE GROUPS

One pertinent question was whether either a dampening or enhancing effect occurred as a result of the presence of the camera and microphones and the knowledge of being videorecorded. In his report on the use of videotape recordings to facilitate the group therapy process, Czajkoski (1968) noted that his group members (prisoners) ". . . gave no overt sign of being unduly concerned with the cameras [p. 519]." The present study offers partial support of Czajkoski's finding. The high level of activity and early establishment of cohesiveness suggested that participation was also minimally influenced by the equipment and taping procedures. When individuals were asked for their reaction, six C and five E members made such statements as: "It didn't bother me" or "I didn't think about it." Their comments suggested that the procedures were not obtrusive to an interfering extent. Members quickly acclimated to the camera; some reported forgetting about its presence:

. . . it was so completely nonobvious, you didn't even think about it. I doubt very much whether there was any difference in (how I participated).

. . . from the minute it got started I didn't even realize the camera and microphones were even there. I didn't even think about it during the meetings.

In the present study there was, however, some indication for a hampering effect of the equipment on certain individuals. One male in each group referred to "inhibitions caused by the camera." In the words of one member:

I think more . . . before I'm gonna say something when the camera's there, because if I know we're gonna see it next week, I don't want to say something stupid.

Both men stated that their participation was affected by the television procedures. Both conceded, probably accurately, that their difficulties in becoming involved with the group most likely would have existed without the camera present. One girl in C did not chew her fingernails, as was her habit, because of the camera. Another referred to "Big Brother watching over you" and considered her words before speaking.

One therapist questioned the possibility the camera may have had an influence on the groups without their awareness: ". . . the camera is a monitor of the (therapy) process whether it's rolling or not . . . it's an extra stimulus to do what they're there to do." In like manner, Czajkoski (1968) referred to the camera's "positive motivating effect" and "the natural association between cameras and performance":

> With cameras switched on, the group seemed less inclined to remain idle or engage in frivolous discussion. It was observed that the small talk that occurs as the group convened changed to more significant conversation soon after the equipment was turned on, without any other kind of prompting . . . In short, the group's sense of mission and economy was apparently enhanced by the presence of the cameras [p. 519].

Another means for assessing the influence of the recording procedures came from C which received no playback. In this group a "deprivation" phenomenon was noted. As treatment progressed, it became apparent that because C was not allowed to view playback, their curiosity was aroused and a great deal of interest and anticipation was generated. One or more members at several points commented about the equipment or about interest in seeing playback. Some asked how other group members who did receive feedback were responding to it, and the like. Wilmer (1966) referred to an extreme form of this feeling of deprivation:

> It is the experience of committing one's image and words . . . to videotape and seeing it rather than the camera which has the greatest psychologic impact. If patients are not shown the replay after video-taping, they tend to develop feelings of disappointment, jealousy, frustration, or a sense of having been exploited [pp. 3-4].

In the present study this extreme was avoided by informing C at the outset that it would be possible after the study to view a tape. This did not, however, totally eliminate their feelings of deprivation.

An interesting observation of E made by a therapist was that despite the group's prevalent hostile atmosphere:

> People would react with each other during the playback to some extent. . . . Often in a more positive way. . . . They would see themselves on the screen, then turn to someone else, talk about it, laugh about it, almost coalesce, and come together with some positive feeling . . . and interaction. Here's something that we could all identify around and relate to, watching this.

REACTIONS TO VIDEOTAPE PLAYBACK

Playback carried the weight of innumerable verbal confrontations for the patients and made denial extremely difficult. It confronted them with the reality of how they presented themselves. In certain E members, self-viewing seemed to result in a noticeable decrease in hostility. Most commented on the television feedback acting as a "refresher" of the events of previous sessions. Besides providing continuity to the meetings, it stimulated in succeeding hours the atmosphere and emotional tone of the last. A further bimodal effect of playback was noted in E. On the one hand, there seemed to be a very marked impact in the reduction of three members' defenses and a challenge to the image that they had been working to preserve in the group. For these individuals, their reaction was to become aware of this image and to realize that it was not constructive and to effect some meaningful changes. One therapist used these words to describe their reaction:

> . . . they haven't been able to maintain . . . their façade. The changes, the kinds of things that have happened to them have been pretty dramatic . . . They've really had to see what they were doing. It made it much more difficult to maintain the postures.

On the other hand, some individuals in the group reacted not with a reduction of defenses but with a reinforcing of their old images to an even greater extent. These students maintained the same posture throughout.

In a recent paper, Berger et al. (1968) noted that:

> The first playback session is extremely important, primarily as a self-image experience [p. 506]. Subsequent playbacks lead to a more profound awareness of pathological interaction and characteristic styles of being and relating. Repeated confrontations enable patients to identify their own self-defeating patterns . . . [p. 508].

In the present study a similar observation was noted. E members' early responses to the playback were characterized by reference to external appearance and gross bodily movement, including posture, level of activity, mannerisms, etc. In later sessions responses dealt with individual images as presented in the group and generally were more profound.

The following examples illustrate the variety of reactions that occurred in this small group of seven members. One woman reacted with delight and surprise at viewing an image of herself that was better than she had expected: "It gave me a more positive image of myself which made me feel very good . . . more confident of myself." Another girl was shocked at what she saw and made a dramatic and effective attempt to initiate some changes in her behavior:

> It gave me the idea that I was a most unnatural person. Everything that I said was so carefully thought out, planned. I didn't like it very well . . . my manner of speaking was so contrived . . . I never realized that. I'd been told before, but I always thought no one is any judge of that except myself. Once you see it, it really hit me right in the face. . . . I decided that I wasn't going to go around wearing Church on my sleeve anymore.

This young woman was able to make use of what she saw by becoming aware of the rigid, moralistic, unaccepting person she was, and then by making some effort to change that image of herself.

Another reaction of a reserved, passive male was to dislike the image he saw, make note of this in the group, but then to retreat and not deal with it directly. He became immobilized, even more unable (or unwilling) to participate than during the first few sessions. Finally, another member evaluated the playback in these words:

> I like . . . playback. It was interesting and helpful. Seeing the same thing next week . . . and seeing how some of the remarks were hostile. . . . You were so caught up in what was going on at the time that when it was played back you could pay attention to how strongly

things were said. When you see yourself the way other people see you, then really you know it, you see it for yourself.

CONCLUSIONS

This paper has demonstrated that videotape playback can play a powerful role in the growth and development of a psychotherapy group. In the present study, the amount and quality of cohesiveness, the manner of interaction of group members, and the ease with which group unity was established were all affected. The different ways that the direct feedback provided by videotape can affect the self-concept and behavior of individuals in a group need to be more thoroughly understood. Only then can therapists become adept at selectively providing feedback which can be a profitable experience for patients. It is not difficult to anticipate that for some people playback may be perceived as a hostile gesture on the part of the therapist. As one member in this study commented, "Once you see it, it really hits you right in the face." Videotape playback can enhance or accelerate the goals of individuals in a group or of the whole group. It is possible, however, that such exposure may result in regressive moves, if not simple defensiveness or denial. With longer-term follow-up studies, it should become possible to identify when, how, and for whom playback can be most effectively utilized.

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The Interpretation of Projective
Identification in Group Psychotherapy

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IN AT LEAST TWO ways, group therapy has advantages over individual therapy. The first lies in the fact that in the group the therapist is given a unique opportunity to observe the behavior of each patient in numerous, diverse, intimate relationships with other persons. From this vantage point, he is in an excellent position to detect inappropriate responses as they occur during the group sessions. Also, because the patients are usually involved in interacting with one another, the therapist is allowed an opportunity to withdraw momentarily from the situation and observe the interactions as they occur.

The fact that the members of the group have an intense, constant, and spontaneous involvement with one another leads to the second advantage. The group members, in contrast to the therapist, are not constrained to maintain a therapeutic, nonjudgmental attitude, and they are not distracted, as is the therapist, by an obligation to understand the dynamics of various interactions. In fact, they are encouraged to respond spontaneously without concern for social propriety. The result of this relative freedom is that the group members often become even more sensitive than the therapist in their reaction to subtly inappropriate behavior in another member. A skilled therapist is in a position to utilize these group reactions as an extra tool in detecting and understanding inappropriate responses occurring during the sessions.

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In the past, many investigators have concerned themselves with the understanding of this sort of inappropriate behavior. From their observations have evolved certain commonly accepted hypotheses to explain that behavior.

The most frequently employed formulation deals with the transference phenomenon as applied to the group: a patient displaces onto the therapist or the members of the group certain feelings which he previously had toward members of his own family, with the therapist usually representing one of his parents and with certain group members representing other members of the family. For example, if a new member is added to the group, the addition may stir up memories of the birth of a younger sibling. In the transference the feelings the patient had in his childhood reappear but are now directed toward a new object.

Another less commonly accepted theory is based on the concept that the patient early in group therapy sees the therapist as an idealized parent. The therapy then consists of an analysis of this misperception. In both the above formulations, the inappropriate behavior occurs when there is displacement of affect from an important person in the patient's past to another individual in the group.

A third approach to the understanding of inappropriate behavior in the group setting centers about the mechanism of projective identification. This mechanism is defined by Hanna Segal (1964) as "the result of the projection of parts of the self into an object. It may result in the object being perceived as having acquired the characteristics of the projected part of the self, but it can also result in the self becoming identified with the object of its projection" (p. 105).

This paper will attempt to elucidate the manner in which many patients repetitively enact the process of projective identification during group sessions. This process occurs as a complex interaction between one patient and the rest of the group. The single patient, whom I shall designate as the target patient, first projects onto the group a certain structural element of his own psyche, either portions of his id, his ego, or his superego. He then reacts to the group as if the group represented that projected intrapsychic structure.

Clinically, this interaction can be recognized as following a rather precise, strikingly repetitive pattern, as if the same scene were being played over and over again. There is a specific sequence to the scene: First, the target patient repeatedly presents himself to the group in a

specific manner which has the unconscious aim of evoking a specific response from the group. Second, the group responds to the target patient always with the identical affective response. The third and final stage is that the target patient reacts to the group, again with stereotyped behavior and affect. This interaction can be demonstrated by the example of a patient in group therapy who repeatedly interrupted the other patients and the therapist. At first, the other group members responded to the interruptions with polite silence. Later, they began to comment, and finally, as the interruptions continued and even increased in number, they began to make more and more hostile remarks toward the target patient. The target patient responded to these remarks by apologizing but almost immediately began interrupting again. After numerous attacks by the group, the patient was obviously crushed; yet, he continued to interrupt. How can this behavior be explained in terms of projective identification? It was clear that the unconscious motive behind the target patient's repeated interruptions was to provoke the attack of other patients in the group and thus to invite punishment for himself. Then the question became: What possible satisfaction could he achieve through manipulating other patients to punish him? Most analysts would agree that a person who invites punishment from the outside world does so as a substitute for punishment from his own overly punitive superego. If this was the case in this instance, then we can see that the target patient was using the critical punishing group as a symbolic projection of his own punitive superego. We are now in a position to explain the peculiar stereotyped behavior.

The first stage occurs when the patient provokes the group by his constant interruptions. This might be described as a training period in which the target patient "teaches" the group to respond with anger to his provocations. If the group reacts to this "training" as the target patient desires, a second period ensues: the group attacks and criticizes the target patient, thus simulating the target patient's own punitive superego. The target patient has now created a conflict between himself and the group which simulates the intrapsychic conflict between his ego and his superego. In the third stage, the target patient reacts to the group as he might react to a similar attack from his own superego. His humble, self-abnegating attitude becomes even more marked, as though his existing feelings of inadequacy are reinforced by the group attack. He now identifies with the group's attitude toward him: after persuading the group

that he is "bad," he humbly accepts their verdict as if it came from the highest of judges.[1]

To summarize the dynamics described in this example: The patient projected onto the group one portion of his psychic structure, his superego. Then, through his provocative behavior, he manipulated the group into reacting in a critical, punishing manner which exactly simulated his superego. He then identified with the group attitude to reinforce his superego censure. Thus, the psyche re-created a model of itself in the outside world.

A similar situation may occur in which a target patient invites criticism from one or the other sex. In one group, a woman constantly provoked the other women to attack her. In this case we can suggest that intrapsychically the same masochistic pattern is present but that the woman target patient has incorporated a maternal superego since she maneuvers to be punished by women. An inverted variation of this occurs when a woman is righteously critical of the behavior of other women in the group, constantly communicating her disapproval of their moral attitudes. We can assume that the woman target patient has projected onto the other women her own id impulses. She then communicates her disapproval of the projected evil in others.

A third type of example occurs when a patient attempts to express ideas which the group finds unacceptable. The group, by overt and covert methods, suppresses the patient's expression of these ideas. The dynamics of this patient are that many instinctual drives are inhibited by a strict superego. The patient has succeeded in projecting his own superego attitudes onto the group and he responds now to the group as if they represented his superego.

THERAPEUTIC MODIFICATION OF THE INTROJECTED OBJECT

If we turn again to the first example, in the final stage of the stereotyped interaction, after the patient has "trained" the group to react in a

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[1] This formulation bears a certain similarity to the "hysterical fate neurosis" described by Helene Deutsch (1965) in which the patient repeatedly creates a situation in which he will suffer the same disappointment. The patient is unaware of his own complicity in arranging the fate. As Deutsch describes it, "The fate neurosis is a form of suffering imposed on the ego apparently by the outer world with a recurrent regularity. The real motive of this fate lies, as we have seen, in a constant, insoluble inner conflict" (p. 27).

specific way, he then introjects the group as a symbolic representative of his own superego. The circular, feedback quality of this mechanism is apparent. First, the target patient projects onto the group certain of his superego attitudes. After the group members have been "educated," the reaction of the group simulates the superego attitude of the target patient. Finally, the target patient introjects this same group reaction, and this introjection serves to reinforce the initial superego attitude. Thus, a neurotic pattern evolves in which an intrapsychic conflict is repetitiously acted out and always resolved in the same, self-perpetuating manner.

But what happens if the expected reaction of the group is changed through an intervention of the therapist? The group then offers the patient a new and different model with which he can identify. A new, less punitive external superego becomes available for introjection. This new superego attitude may be incorporated and substituted for the old, more pathological attitude.

An example of an intervention which sets the stage for a more therapeutic interaction by the group is as follows. A patient tends to act out impulsively outside the group, repeatedly bringing in problems which appear to be acute crises requiring immediate resolution. The group responds to his frantic demands for immediate action by becoming anxious; then, as their anxiety increases, they are forced to agree with the demands of the more aggressive target patient. The therapist is able to understand this interaction in the following way: intrapsychically the target patient has a weak ego which is unable to withstand instinctual demands thrust upon it by an overwhelming id. The patient first makes the group into an external ego, then he attempts to persuade the group that his instinctual drives should be gratified.

With this information at his disposal, the therapist is able to guide the group into dealing with this problem in a therapeutic manner. He points out that the group has become anxious and that because of their anxiety they have agreed to certain unrealistic demands of the target patient. The group responds to this intervention with a lessening of anxiety and becomes able to undertake a calm investigation of various aspects of the target patient's problem. After a great deal of questioning and after numerous possible resolutions to the problem have been suggested, the target patient is then in a position to work out a better solution to his problem.

When the ego of the target patient is too weak to provide the necessary delay required for adequate reality testing of the problem involved, with the therapist's guidance the group can provide an extended interval between the moment when the patient demands a solution to his problem and the time when the solution is finally worked out. If the patient is able to incorporate this external model of ego functioning, his ego may in the future be able to provide the necessary delay required for adequate reality testing.

The substitution of group superego attitudes for the patient's own more punitive superego is a particularly effective therapeutic maneuver. The therapist's task is twofold. First, he must recognize that by a mechanism of projective identification the patient has projected his own superego attitudes onto the group and is now responding to the group as if they represented a strict repressive superego. He is then in a position to point out to the group that they respond critically to the target patient. With this confrontation, the group will usually become more accepting and tend to ignore any maneuvers by the target patient to provoke criticism. As the group behaves in a less critical manner, they automatically offer to the target patient a new model for incorporation.

At times, even without the intervention of the therapist, the group may spontaneously present a healthy, therapeutic response to a target patient's manipulations. For example, a patient revealed certain sexual fantasies to the group in a shamefaced manner, as if to say, "I know that, no matter how politely you may act, you secretly disapprove of me." Despite all the patient's invitations to disapprove, however, the group instead told the target patient that they found nothing disgraceful in the sexual fantasies. In this instance, each patient in the group offered his own less punitive superego as a model for the target patient to introject.

SUMMARY

This paper offers an approach to the conceptualization of certain stereotyped interactions seen in group therapy. These interactions are seen as attempts by individual patients to re-create, in the group, their intrapsychic conflicts through the mechanism of projective identification. The interaction occurs through the patient first "training" the group to react in a stereotyped manner to certain repeated provocations. The group's reaction simulates the attitude of the projected portion of the

"target" patient's psyche. Thus, the conflict between the target patient and the group simulates the intrapsychic conflict of the target patient. Finally, the target patient may reintroject the group's attitude. Several clinical examples are cited.

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Structured Separation of a Key Physician from a Therapeutic Community

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WHILE THE LITERATURE ON the facts and phenomena surrounding the incorporation of new members into clinical settings is quite rich, the literature on separation of personnel from clinical settings utilizing the many and varied group vehicles is surprisingly lean. The entire area of separation of personnel from administrative and institutional settings is disproportionately dealt with in the literature, although there are exceptions (Cohen, 1957; Stotland and Kobler, 1965). This is especially true of the many clinical settings which have come to be known as therapeutic communities or milieus. The present study was inspired by observation of the stressful effects of the departure of physicians from clinical settings coupled with the need for a pragmatic solution to a realistic problem.

BACKGROUND INFORMATION

The departing physician in this experiment had been deeply involved in the elaboration of a treatment program and was an important team member who had heavy clinical and teaching responsibilities. When he originally arrived at the institution, the team was aware that he would be there for a two-year period and no longer. As the time of

his preplanned departure drew near, there was no hope for an immediate replacement for him, which meant that the team would be left with only one full-time psychiatrist in a hospital unit with an average census of 275 patients.

The departure of a meaningful member of a therapeutic community creates "vacua" which must be "enveloped," to borrow from Jones's (1965) terminology. His departure produces many realistic as well as psychological stresses in the therapeutic community, especially if this community, due to the common problem of inadequate professional staffing, has come to rely heavily on this individual.

Examination of the history of departures of key personnel in this particular setting may be helpful in providing additional perspective on the case in point. When the unit was originally formed as a team, there were three psychiatrists, three social workers, one psychologist, one chief nurse, two additional R.N. supervisors, plus a complement of two occupational therapy workers, a recreational therapist, an industrial therapy coordinator, and psychiatric aides of varying experience and job rating, totaling 84. At the end of a two-year period, the staff was down to two psychiatric physicians, one social worker, the chief nurse, and one R.N. supervisor. Reduction in the number of aides tended not to quite parallel the professional staff loss. Because of the particular circumstances in this general hospital, there was no realistic assurance that additional staff would be hired to fill the vacancies in the foreseeable future. Thus, the unit faced the dim prospect of having to continue with a much reduced staff, which would include only one psychiatrist.

THE PRAGMATIC PROBLEM

Two physicians had been extending themselves for some time to fill the vacua left by the departure of the psychologist, social workers, and the third physician. The nursing service had been prodded and encouraged to engage in group activity of many types, varying all the way from large biweekly ward meetings to small group activity of varying sorts, and their need for support was realistic and understandable. Also, their numbers had dropped to a low of 70. It was in these circumstances that one of the physicians who was directly responsible for the care of over half of the patients and for the elaboration and the maintenance of the program on four of the seven wards was to depart.

It seemed quite obvious that for the physician to leave without previous team planning and preparation might well sentence this unit to its only recently buried custodial orientation. It was felt that reorganization and structured withdrawal and separation of this physician from this particular team might spare this community considerable demoralization and regression to a more dated stage while simultaneously providing an opportunity for some clinically based research.

THE PLAN

When the physician became aware of separation anxiety in the patient population and the ward personnel, which, interestingly enough, appeared in both at the same time and followed an out-of-state journey made by the physician five months prior to his scheduled date of departure, he called a team meeting to discuss the problem. The personnel were told the rather bleak news of his leaving in a straightforward manner, and two alternatives were described: either the program could continue as structured right up to the time of the physician's departure, or the team could modify the program in an attempt to try to survive the loss by an increased, coordinated team approach. The team was given marked encouragement in the latter direction, and a tentative 90-day trial period was set up to try certain modifications. The major changes involved ward personnel continuing group activities with much less participation and direct support from the departing physician and the gradual shifting over of the patient population to the remaining physician.

The physician established a series of workshops on his four wards for both the day and night shifts. They were held on a weekly basis, totaled 18 in number, and were to last throughout the 90-day period to deal specifically with problems engendered by the changeover. The physician also continued to attend the daily morning meeting and all general team meetings. At the end of the 90-day period, it was planned that the team would be subjected to a one- or two-week period with only one physician present. After this testing period, the entire process would be assessed by the team and any alterations felt to be necessary could be attempted or implemented while the team still had its two full-time physicians during the last four-week period prior to the physician's departure. In addition, the departing physician was scheduled to give two

formal lectures on "separation phenomena" shortly after what was considered to be the climax of the process.

REPORT OF PROCESS

Although the team enthusiastically accepted this roughly sketched plan, the reactions were not long in coming. Ward personnel, with whom the physician had long ago worked out certain problems, again began approaching the physician for support they had long since ceased needing, and they showed reluctance to relate to the "new" physician. They asked how they could be expected to carry on their groups when they were "just beginning to understand them a little." They became critical of the physician's teaching techniques, which had always had a reflective quality, and some complained that they felt they were being "analyzed." Patient problems were collected for the departing physician to handle, their piling up amounting to a form of sabotage, and supervisors continuously relayed sounds of discontent. Some personnel became indignant in response to the physician's suggestion that they consider examining their feelings toward him; these were, of course, the same personnel who were so capable of identifying analogous phenomena in the patients. Pleasantly enough, and as might be expected, the personnel who had had the greatest exposure to the physician and who had had the most intense inservice experience were the first to recognize their anger at him over his departure because of the additional responsibilities they had to assume, the prospective loss of support, and their feeling of abandonment.

"You came here and got all these things going and now you leave us." This was the honest, vexed, and pointed confrontation.

The entire process climaxed in a team meeting in which the nursing personnel stated that they were overtaxed and could not support the program as constituted. The precipitating event was the unilateral structuring of groups by the physicians for a newly acquired consultant who was to come in once a week. Ward and staff personnel were to be involved in these groups, and realistically it was an extra demand on their time. In any event, the meeting was more notable in the opportunity it afforded nursing personnel to ventilate their feelings than it was in producing a great number of changes, for, interestingly enough, when given

the alternative of curtailing some of the program, they declined, commenting that they could not bring themselves to eliminate any of the long-worked-on projects.

Subsequently, there came a rapid, general recognition by ward personnel of anger at both physicians: anger at the departing physician for leaving and anger at the other physician because he was team leader and thus the target of blame for having let such a state come about. In addition, the new psychiatric consultant became the target for some of this displaced anger.

Approximately ten to 14 days prior to the end of the experiment, for all practical purposes the goals had been accomplished. Ward personnel were again feverishly working on all projects; the "new" physician was appropriately installed; the "old" physician began to be the receptor of looks of curiosity (extra team appendage) rather than of anxiety, avoidance, and anger. There was even a return of the friendly feelings which had been previously enjoyed.

DISCUSSION

In many ways, the structured separation was analogous to other separation processes. The results were highly suggestive that this approach might be effectively utilized in therapeutic communities and other organizations. It appears to offer a more stable, manageable, postseparation period. In this instance, much was felt to be accomplished in terms of maintenance of team morale, team structure, and a continued viable program.

To carry out such a process requires a particular type of administrator, and probably not many settings or administrators, unless practiced in nonsystematized techniques of clinically oriented group management, would think it necessary. From a practical standpoint, it is not easily appreciated that such a complicated procedure could replace the usual rituals (recognized and unrecognized) for handling such situations.

The major texts on administration in psychiatric settings are painfully lacking in discussion of this topic, and it is hoped that this paper may serve to stimulate comments and observations. This observer was left with the feeling that the entire theme of separation and loss is a nuclear force in the life of man, up and down the psychosexual developmental chain, but that the end-phases of human operations tend to be

left neglected in the absence of significant, ritualized, or triumphant end-points.

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Jest Appreciation and Interaction in Leaderless Groups

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Since a sense of humor has often been mentioned as the *sine qua non* of the mature person (Freud, 1928), it is paradoxical that very little time and effort has been expended in attempts to define and measure this key concept. Freud made a pioneering effort to equate maturity with the sense of humor, theorizing that both the production and appreciation of humor mirror the triumph of narcissism and the pleasure principle over an array of stressful environmental circumstances. His chief example was "gallows humor" in which the protagonist did not decompensate under the pressure of his imminent death and instead responded with non-hostile jests to the inescapable circumstances. Freud contrasted such a person with the tendentious wit who finds release for repressed hostile impulses via appreciation and creation of hostile wit. He also mentioned resignation, a mechanism which shows a "magnificent rising" above external stressors but lacks the liberating pleasure of humor. The implication was that humor preferences reflect maturity, while resignation and, in particular, hostile wit appreciation are signs of a relative immaturity.

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Little has been written of the influence of the death background in Freud's views of humor (O'Connell, 1968). Is it the confrontation with death which gives humor its distinct characteristics? Or is death merely one of many nonspecific stressors which when faced courageously give pleasure to certain people?

No research has attempted to correlate the intensity of humor, hostile wit, and resignation preferences with subsequent peer group evaluations. Where the evaluation of others has been considered, as in the case of hostile wit, such judgments have never been based upon ratings produced by members of groups engaged in the intense mutuality of sensitivity training (Rothaus, et al., 1963; Hanson, et al., 1966).

This project represents a step in the direction of finding meaning for the psychoanalytic concepts of humor, wit, and resignation appreciation by correlating the preference for these jests with group behavior items judged by peer group members. Specifically, the hypotheses are: (1) appreciation for Freudian humor jests with death themes is associated with mature, group-centered, problem-solving activities; (2) preference for hostile wit and resignation is linked with immature dependency and avoidance reactions to group tasks.

METHOD

The Ss were 184 male veterans (aged 28 to 56, $\overline{X} = 40.5$, $s = 8.7$), members of 22 self-directed development groups (D-groups) which met daily for twenty one-and-one-half hour sessions over a period of four weeks. The D-group is part of the Human Relations Training Laboratory, VA Hospital, Houston, Texas, and meets for the purpose of exploring each person's attitudes, feelings, behaviors, and goals as they operate in the here-and-now and as they have contributed to back-home problems (Hanson et al., 1966).

As part of this psychiatric treatment each patient rated his peers weekly on the Group Behavior Questionnaire (GBQ). The 18-item sociometric test required the choices of two people from the D-group who best exemplified by their group interactions the behaviors described by the questionnaire. Each patient's index score was based on the number of peer choices received divided by the number of choices he might have received over a four-week period of time (Rothaus et al., 1966).

The psychometric scores for humor, hostile wit, and resignation were

measured by the Story Test (O'Connell, 1964, 1968) administered upon
admission to the Patients' Training Laboratory program. In order to
estimate the degree of death present in the 18 jests, the latter were pre-
sented without the endings to five VA clinical psychologists. Six items
were selected to represent high-death situations and six to reflect the
opposite extreme of low-death stories. The six "neutral" items were not
included in this study of the effects of the presence or absence of death
in the jest (O'Connell, 1968).

RESULTS

A rotated verimax factor analysis was used to find a descriptive pat-
tern for the sociometric test. The three factors extracted accounted for
78 per cent of the variance of the GBQ. The item loadings of the socio-
metric test for the main factors of prominence, avoidance of conflict, and
hyperdependency are given in Table I. The discrepancy in numbers be-
tween subjects used in the factor analysis (N = 721) and jest study
(N = 184) is explained by the fact that the GBQ has been a laboratory
instrument for many years longer than the Story Test. Scores for each
S on the seven items of Factor 1, the six questions of Factor 2, and the
five statements of Factor 3 were summed for each factor and called the
aggregate scores. The correlations between aggregates were prominence
and hyperdependency, —.565; prominence and avoidance of conflict,
—.319; and avoidance of conflict with hyperdependency, .216.

Table II shows the correlations between the Story Test variables and
the main sociometric factors. It is interesting to note the differences in
trends between humor appreciation and the other jest categories on
Factors 1 and 3. Humor appreciation correlated positively with prom-
inence and negatively with hyperdependency, but not to a significant
degree. The converse was true with hostile wit and resignation: negative
associations with prominence and positive ones with hyperdependency.
The same pattern held for Factor 2 with the exception of a positive sig-
nificant relation between avoidance of conflict and low-death humor
preference (r = .14, p = .05).

On jokes with a strong element of death, hostile wit was negatively
related to prominence and positively associated with avoidance of con-
flict and extreme dependency (r's of —.15, .15, and .15, p <.05). Under
like conditions, resignation appreciation concurred with peer ratings of

TABLE I

LOADINGS OF THE GROUP BEHAVIOR QUESTIONNAIRE ITEMS
ON THE THREE SOCIOMETRIC FACTORS

GBQ Variables	Factor 1	Factor 2	Factor 3	h²
Factor 1: Prominence				
4 Which two are most highly accepted by the group at large?	.8799	.1169	-.3009	.88
16 Which two have tried to do the most to keep the group "on the ball"?	.8711	.0050	-.3157	.86
7 Which two require *the least help* in keeping up with group and lab activities?	.8548	-.1309	-.3226	.85
11 Which two seem to be the genuine leaders?	.8454	-.2362	-.3221	.87
1 Which two members of the group can *most easily* influence others to change their opinion?	.8436	-.2034	-.3193	.85
9 Which two have shown the greatest desire to accomplish something?	.8234	-.0086	-.1627	.70
17 Which two do *you* usually *talk to* the most?	.7983	-.1879	-.2467	.73
Factor 2: Avoidance of conflict				
3 Which two have clashed most sharply in the course of the meetings?	.1924	-.8927	-.1318	.85
13 Which two have shown the most hostility in group meetings?	.0755	-.8736	-.0394	.77
8 Which two try most to get attention from other group members?	.3073	-.8242	-.1143	.79
15 Which two have competed the most with others, in the sense of rivalry?	.4106	-.8120	-.2194	.88
10 Which two have been most ready to discuss topics not directly related to the group's task?	-.1296	-.7067	.0388	.52
14 Which two have wanted the group to be warm, friendly, and comfortable?	.5254	.5107	.0122	.54
Factor 3: Hyperdependency				
2 Which two are least able to influence others to change their opinions?	-.3060	.0446	.8940	.89
12 Which two have shown the strongest need for direction and support?	-.2553	.0130	.8792	.84
6 Which two depend most on the group members or staff in keeping up with group and lab activities?	-.2523	.0103	.8739	.83
5 Which two give in most easily to what other group members want?	-.2006	.3628	.8257	.85
18 Which two do you usually *talk to* the least?	-.3682	.0590	.6625	.58
Per cent total variance	33.35	22.00	22.92	
Eigen values	8.5835	3.4913	2.083	

TABLE II

CORRELATIONS BETWEEN STORY TEST VARIABLES AND SOCIOMETRIC FACTORS

	Factor 1 Prominence	Factor 2 Avoidance of conflict	Factor 3 Hyper-dependency
High-death humor	.093	−.029	−.045
High-death hostile wit	−.165*	.163*	.166*
High-death resignation	−.087	.187*	.157*
Total High-death	−.074	.134	.118
Low-death humor	.068	.141*	−.093
Low-death hostile wit	−.144*	.138	.128
Low-death resignation	−.089	.103	.236**
Total low-death	−.073	.066	.108
Total humor	.093	.066	−.080
Total hostile wit	−.168*	.163*	.160*
Total resignation	−.098	.163*	.216**
Total humor, hostile wit, and resignation	−.077	.157*	.120

$* = p < .05$
$** = p < .01$

avoidance and hyperdependency. With low-death jests there was no noticeable relationship between hostile wit preferences and Factors 2 and 3. The jest correlations with Factor 2 under minimal death situations were positive only with humor appreciation. The strongest correlation of the study was that of low-death resignation appreciation and hyperdependency ($r = .24$, $p < .01$).

DISCUSSION

The first hypothesis which predicted a relationship between humor appreciation and mature behavior (i.e., prominence ratings by peers) was not validated by the findings of this study. High-death humor appreciation did mirror this hypothesis by its correlation trends (positive with prominence, negative with hyperdependency and conflict-avoidance); yet, significance was reached with hostile wit preferences only. The more one is judged to be prominent by his peer group, the less he appreciates hostile wit. It may be that there is no empirical relationship between the group- and task-oriented prominent person and the Freudian humorist. The latter could be very inner-directed and therefore unlikely to put

extreme demands upon external factors for happiness. He may be committed socially, but the prime object for change might be inner tasks akin to Frankl's "realization of additudinal values" (Frankl, 1955). The lack of a primary external focus would account in part for those with the greatest high-death humor appreciation scores having relatively low total Story Test scores (high-death humor and total, $r = .70$; high-death resignation and total, $r = .83$, $t = 4.11$, $p < .001$). The Freudian humorist may have his energies channeled in the direction of inner activities at the expense of intense outer action, and therefore receive no outstanding ratings on group tasks.

Although almost half of the correlations between the six independent jest variables and sociometric factors reached significance at the less than five per cent level, the degree of significance between jest preference and the sociometric factors was not high (range of .145 to .236). Apart from a possible lack of intrinsic association between the two behavioral realms, there are other mitigating factors which might have lowered the correlations from otherwise high values. The restricted range of the S sampling (hospitalized patients) might mask a higher correlation which could obtain over a full continuum of maturity from the most to the least. For example, it seems probable that those scoring high on the prominence factor on this restricted sample would not show the same quality of responsibility and self-esteem as creative leaders of the community. Neither would patients selected for sensitivity training display the extremes of avoidance and hyperdependency to be expected from the chronic patients of the traditional psychiatric ward. This may be partly responsible for the failure of high- and low-death humor, theoretically measures of maturity, to be highly related to the interactional factors. The trend was there, but the strength was not. The Story Test variables correlated negatively with prominence, and positively with avoidance of conflict and hyperdependency with the exception of the humor categories, which, for the most part, were associated in the opposite direction. The possibility also exists that the Story Test is too difficult a test for the hospitalized patient. About one-third of such Ss show some inconsistency between their ratings and absolute choices on jests, raising the question of understanding of the jest itself. Future research will be oriented more toward wit, humor, and resignation cartoons for easier comprehension, with an opportunity to score for understanding. The criticism of restricted range applies to quantity as well as quality of Ss. In

addition to the sample restriction to a type of hospitalized mental patient, the small number of people in a peer group might have precipitated strained forced choices. In some groups prominence, conflict avoidance, and hyperdependent behaviors might have been absent, in others overly present. It seems more likely to expect the first factor to be low and the other high with a hospitalized population. Yet, in groups of only six participants it is quite possible for all members to be selected as high in one of the three factors, regardless of the absolute strength of the construct in each group. These possible attenuations did not completely obscure the intrinsic relationships which are reported in this study and add to the meaning of both jest appreciation and peer group behavior.

The second hypothesis relative to hostile wit and resignation preferences being related to immature behaviors is confirmed by this study. The totals of the Story Test show positive correlations between wit and resignation appreciation and avoidance of conflict and hyperdependency as judged by peers. Freud's early view of wit as a neurotic device seems confirmed, but he failed to see resignation preferences as more pathological than mature.

High-death jests may be viewed as adding a stressor factor to the low-death variety and hence as accentuating conflicts. In this study the greatest change from low- to high-death patterning of jest appreciation was noted with Factor 2, the avoidance of conflict. Under low-death jest stimuli, the significant correlation was with humor and the second factor. The addition of stress (high-death) elements changed the significant jest correlations to positive relations between Factor 2 and hostile wit and resignation. It may be, therefore, that those who avoided conflict resorted to more immature jest preferences when faced with an increase in death ideation. This picture is reinforced by the lack of wit change for the prominence factor under high-death stimulation.

SUMMARY

This study represents an effort to give meaning to Freud's neglected concept of maturity, the sense of humor. It is also an effort to add understanding to two other behaviors contrasted with humor, the appreciation of hostile wit and resignation. The Story Test was administered to 184

male veterans entering development groups. The Ss obtained a score for humor, hostile wit, and resignation by rating the three endings for each of the 12 test items for preference. The body of half the anecdotes was considered high-death if death was an integral part of the theme, low-death if it was absent. At the end of each week during the sensitivity training, the members of each group chose peers who exemplified the behaviors described in the 18-item Group Behavior Questionnaire. These four scores were averaged and compared to Story Test categories.

Each S's aggregate scores on the three sociometric factors (prominence, avoidance of conflict, and hyperdependency) were correlated with his high- and low-death humor, hostile wit, and resignation preferences. High-death humor appreciation, Freud's specific example of maturity, did not correlate significantly with the three factors for this patient sample. Both high-death and low-death hostile wit were negatively related to prominence. High-death hostile wit and high-death resignation had positive associations with avoidance of conflict and hyperdependency. The strongest relationship was a positive one between hyperdependency and low-death resignation appreciation. Low-death humor, unlike the high-death variety, had a positive correlation with avoidance of conflict. It may be that those who avoid conflict find death ideation stressful and resort to wit and resignation preferences when under tension.

The findings add credence to Freud's early view that hostile wit is a mechanism of maladjustment. Resignation appreciation did not seem to have the degree of maturity associated with it by Freud and likewise appeared to reflect immature avoidance and dependency. High-death humor was not correlated with the avoidance and dependency factors and, with the clinical population used, was not related to prominence.

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Group Counseling with Underachievers:
A Review and Evaluation of Methodology

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WITH THE REAWAKENING OF public interest in education that occurred during the 1950's, research into the problem of underachievement began to increase. This development can be attributed to the national concern for the effective utilization of the many college and high school students functioning below the level of their academic potential (DeWeese, 1960). Although in recent years the emphasis on the identification of under-achievers has changed to an emphasis on treatment, the problems in-herent in their identification have not been dealt with adequately. Thorndike (1963), for example, cited four major sources of error in the prediction of academic achievement: sampling errors, criterion hetero-geneity, the scope of the predictor, and the impact of uncontrollable life experiences.

Perhaps the major obstacle to improving the identification and, thereby, the treatment of underachievers lies in the definition and clarity of the concept. Measured academic performance has been the most fre-quently used criterion against which treatment procedures have been tested. Yet, several studies suggest (Tiedeman, 1960; Farquhar and Payne, 1964; Harrington et al., 1965; Hummel, 1966) that the manifestations of underachievement probably vary with the chosen measures of aca-demic performance and the corresponding measures of achievement discrepancy. It is probably inaccurate to consider the underachievement

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of gifted students as the same psychological phenomenon as the underachievement of less able poorly performing students. Another problem in the identification of underachievers lies in differentiating chronic underachievers from those students whose poor academic performance is to a great extent situationally determined (Spielberger and Weitz, 1964). Myers (1966, p. 376) cogently stated the present confusion of researchers in integrating discrepant findings: "Conflicting and non-complementary findings abound, studies of only local applicability flourish, and students continue to ignore regression equations."

Other investigators (Baymur and Patterson, 1960; Spielberger et al., 1962; Spielberger and Weitz, 1964; Taylor, 1964; Chestnut, 1965; Harrington et al., 1965; Siegel, 1965; Dickenson and Truax, 1966; Teahan, 1966; Goodstein, 1967; Gilbreath, 1967a; Leib and Snyder, 1967) have emphasized psychodynamic rather than actuarial factors in the identification of underachievers, stressing that academic difficulties may be symptomatic of underlying individual and family pathology rather than intellectual deficit. For example, Taylor's review of the literature suggested seven major personality dimensions along which to distinguish underachievers from overachievers.

While it is felt by some that underachievement is a false issue and that there is no specific behavior syndrome which can differentiate its occurrence from that of other personality problems, to postpone treatment of the problem because of difficulties in its conceptualization and operationalization is tantamount to denying its existence. Thus, in spite of these problems, research continues, as well it should, in the treatment of underachievers, yet with at times minimal awareness of the limitations imposed on such treatment by the more academic concerns suggested above.

Most concerned parties now accept underachievement as a psychological and social reality and, therefore, have attempted to deal with its occurrence and, to a lesser extent, its prevention (Spielberger and Weitz, 1964). Smith and Walsh (1968), in a brief review of the literature, found four major approaches to the treatment of underachievement: prolonged intensive therapy, multiple treatment, individual counseling, and group counseling. Baymur and Patterson (1960) Hogue (1965), and Hill and Grieneeks (1966) reported studies on the effectiveness of individual counseling. The results of these studies varied, and Munger et al. (1964) concluded that the evidence for the effectiveness of individual counseling

as a method of improving academic performance was not conclusive. If, in fact, underachievement does arise from more global personality difficulties, the overall inconclusiveness of these and other studies is not inconsistent with the findings of Eysenck (1961) on the ineffectiveness of psychotherapy.

Dissatisfaction with the outcome of individual counseling of underachievers has led many investigators to consider the potential usefulness of group counseling, both because of its likely economy and because of an interest in applying a rather well-integrated body of research on group dynamics to one of our major educational impasses. The results of studies using group methods are conflicting and ambiguous (Shaw and Wurston, 1965). Chestnut (1965) found that leader-structured groups of underachieving male college students improved students' grades at a faster rate than group-structured groups, but three months after counseling the leader-structured Ss were no longer performing significantly better than group-structured Ss. Gilbreath (1967a) found that differential group structuring did have an effect on the outcome of counseling underachievers, with Ss who were more dependent and emotionally constricted more likely to improve their grades in a high-authority, leader-structured group and the more autonomous students more likely to improve their GPA under low-authority, group-structured conditions. Broedel et al. (1960), Baymur and Patterson (1960), and Laxer et al. (1966), all using between eight and ten group sessions, concluded that short-term counseling of male high school underachievers was relatively ineffective in improving academic performance. However, Broedel et al. and Laxer et al. suggested that group counseling did influence personality variables that were related to general school adjustment. Dickenson and Truax (1966) hypothesized that high conditions of therapist-offered empathy, nonpossessive warmth, and genuineness would be more effective than low conditions in counseling a group of male and female college underachievers, and their results supported this hypothesis.

The findings of these studies do not show clearly consistent differences between counseled and noncounseled groups. Smith and Walsh (1968) concluded that this ambiguity could be attributed to the contradictions in the outcome results, and Farquhar and Payne (1964) commented that different methods of identifying underachievers may actually produce different populations, so that comparisons of results would be ineffectual, for the uniqueness of the samples might alone account for the apparent

contradictions. Although Farquhar and Payne were concerned with the identification of underachievers, their comments seem relevant to the treatment of underachievers as well. The treatment method itself stands out as an area filled with methodological enigmas. In reviewing the literature, this writer found studies on the effectiveness of individual counseling, group counseling, and comparisons of these methods, yet noticed almost a total absence of reports on the treatment methods per se. While much research energy has been expended on identification, prediction, and outcome studies, little attention has been focused in the recent literature on the analysis of the group counseling methods actually used in such studies. The purpose of this review is to integrate recent research findings and observations of some of the methodological problems often encountered, yet inadequately analyzed, in the group counseling of underachievers.

GROUP MEMBERSHIP VARIABLES

It is possible that the confounded and confounding results of previous research can be attributed, at least in part, to errors other than those involved in the identification of underachievers. Careful scrutiny of the literature suggests that other group membership variables may be contributing to the general inconclusiveness of previous studies.

Age

One of the problems in evaluating the effectiveness of group counseling with underachievers is the difficulty of comparing results obtained from different age groups. Studies have been conducted on elementary school students (Munger et al., 1964; Winkler et al. 1965; Southworth, 1966; Burdon and Neely, 1966) and junior high school students (Broedel et al., 1960; Cohn and Sniffen, 1962; Cubbedge and Hall, 1964; Laxer et al., 1966; Laxer and Quarter, 1967), but most of the research has been focused on high school and college students. The results of having studied such a wide range of student groups is that the designs of some studies (for example, Munger et al., 1964) have been based on the findings of research conducted with inappropriate age groups. A second obstacle has been the failure to specify the ages of the Ss. Most studies report that they have been conducted with "college freshmen" or "high school students" without specifying the mean age of the Ss. Studies by

Thoma (1964) with high school girls, Burdon and Neely (1966) with elementary school students, and Dickenson and Truax (1966) with male and female college students are rare examples of reports in which the ages of the group members have been made clear. A danger in the lack of such specificity in most other studies is that research on underachieving college freshman, for example, may have drastically different meanings if the students are 17 and 18 years of age than if their ages range from 17 to, say, 30. It seems reasonable to state that underachievement is qualitatively and phenomenologically a different problem for students of different ages.

Sex

It is perhaps indicative of many of our unquestioned cultural values that while research on the underachieving male student abounds, there is a dearth of such research on the poorly performing female student. The writer was able to locate only one published report that dealt solely with a group of underachieving girls (Thoma, 1964). Even the research on combined male and female underachieving groups is meagre (Baymur and Patterson, 1960; Broedel et al., 1960; Siegel, 1965; Dickenson and Truax, 1966; Teahan, 1966). It is unfortunate that the research on underachieving students does not reflect the generally accepted role of females in American education.

Antecedent Variables

Antecedent variables which might affect the outcome of group counseling are also noticeably absent from the recent literature. Reports of such factors as previous psychotherapy or counseling and overt family pathology such as divorce or alcoholism are rarely found in the literature. The reviewer located only one article in which the student groups were controlled for overt pathology in either themselves or their parents (Burdon and Neely, 1966). Yet, an unpublished report of a group counseling project with 13 underachieving high school male sophomores (Herrold et al., 1968) suggests that these factors may have differential effects on the outcome of the group counseling experience.

Psychoanalytic theory maintains that sibling rivalry may facilitate certain neurotic conditions. If underachievement is, in fact, symptomatic of underlying personality difficulties, then both the birth order of underachieving students and the number of their siblings may be participating

agents in the development of this behavior pattern. Yet, there are few studies of underachievers which take account of the number of siblings of the underachiever (for an example of one that does, see Southworth, 1966), and no studies are known to the writer which consider birth order as a possible factor in underachievement.

Another pair of antecedent variables commonly unspecified in the literature are socioeconomic status and parental educational level. A large proportion of the research on the treatment of underachievement has been conducted with college students and high school students from suburban areas, and there is, consequently, little or no information available on the effectiveness of counseling with underachieving disadvantaged students, for most of the research on underachievement has been geared (not unlike research in most other areas of psychology) toward the middle class.

In summary, it seems reasonable to conclude that several counselee variables that may have either a direct or an indirect bearing on the occurrence, intensity, and duration of underachievement have been either ignored or insufficiently attended to.

GROUP PROCESS VARIABLES

Theorists and practitioners have expressed many different views on the ideal length of counseling and psychotherapy. Tyler (1960) favors short-term counseling (what she calls minimum-change therapy) which ends when the goal that has been sought by the client is reached or when a client's behavior indicates change in the desired direction or at least stabilization. Psychoanalysts urge that therapy be extended over a long period of time, often years (Ford and Urban, 1963). Reports from behavior therapists suggest that effective therapy can occur in some types of conditions with far fewer contacts than are required by analytic therapies (Wolpe, 1958). The problem of the ideal length of counseling is an important one in counseling underachievers. The modal number of group sessions in the counseling of these students appears to be from 8 to 15, usually lasting from half a semester to an entire semester, i.e., two to four months. Most studies report using 45- to 60-minute sessions, with a handful using 90-minute sessions (Chestnut, 1965; Burdon and Neely, 1966; Gilbreath, 1967a; Thelen and Harris, 1968).

The results of several studies suggest (Baymur and Patterson, 1960; Broedel et al., 1960; Mahler and Caldwell, 1961; Chestnut, 1965; Laxer et al., 1966; Goodstein, 1967; Whittaker, 1967) that short-term counseling is probably ineffective in improving the academic performance of under-achievers, although there may be immediate but transitory attitudinal changes as the result of counseling. At least five writers mention or imply the existence of an "incubation period" through which clients must pass before there are noticeable effects from the counseling experience (Baymur and Patterson, 1960; Campbell, 1965; Laxer et al., 1966; Goodstein, 1967; Mezzaro, 1967). Goodstein's five-year follow-up of the effectiveness of group counseling with probationary college students makes this point most vividly. Studies which have used group counseling for five months or more seem to report better results than those in which only very brief counseling was used, although reports of such extended counseling are scarce. Thoma (1964) found that after thirty sessions with under-achieving high school girls, there was significant academic improvement for 37 of the 43 girls in her study; Siegel (1965) reported that after 22 sessions with a male and female group of underachieving college students, the mean WAIS I.Q. of the nine students increased from 119 to 129, and Dickenson and Truax (1966) reported that 24 sessions with high therapist-offered conditions produced significant changes in both the academic performance and attitudes of the male and female students counseled in the same group.

A second major area of interest in the process aspects of group counseling with underachievers is concerned with specific counseling techniques. These techniques tend to fall into three categories: group-structured—modeled after the Rogerian approach to psychotherapy; leader-structured—the information-giving, problem-solving, and topic-setting by the counselor approach; and analytic—the depth-probing approach modeled on psychoanalytic therapy. No clearly significant differences in the effectiveness of these techniques have been found when applied to underachievers. Yet, there seems to be a *tendency* for groups with more active counselor participation (leader-structured) to produce more positive behavioral and academic change than the other approaches. Baymur and Patterson (1960). Thoma (1964), and Patterson (1965), all studying high school students, concluded that leader-structured groups produced greater improvement in academic performance than analytic

or Rogerian-type groups, and Chestnut (1965) and Gilbreath (1967a, 1967b) reached similar conclusions in studying the effectiveness of leader-structured group counseling with male college underachievers.

In view of the recent interest in various behavior therapies, it is surprising that although these techniques have been applied in groups for information-seeking behavior (Krumboltz and Thoresen, 1964) and test presentation and interpretation (Holmes, 1964; Ryan and Krumboltz, 1964), no studies have yet appeared in which planned reinforcement of client behavior has been the focus of group counseling with underachievers. It is possible that there is much to be learned by applying these techniques to the treatment of underachievers and that such studies will appear in plenty in the near future.

A problem which is inextricably bound up with the specific technique used in any study of group counseling with underachievers is the clarity of the technique as stated by the investigators. Most research reports do not provide adequate descriptions of the techniques actually used in the conduct of the study. Chestnut (1965), on the other hand, had his student subjects fill out questionnaires at the end of their group counseling to determine the degree to which the group leaders had adhered to their stated techniques. Gilbreath (1967a) provided another method of verifying counselor technique by having independent judges observe the group sessions and estimate the counselor's behavior according to predetermined criteria. Leib and Snyder (1967) combined these methods of verification of counselor style by obtaining ratings from both their subjects and from independent judges. If counselors expect to be able to compare the results of various types of group counseling with underachievers and to replicate previous studies, there must be a high degree of certainty that the stated counselor techniques have closely approximated the counselor's actual behavior. Only the three studies cited above have met this requirement.

COUNSELOR VARIABLES

The importance of counselor characteristics in facilitating or impeding progress in counseling and psychotherapy has been emphasized by many writers and researchers (Rogers, 1942, 1951; Fiedler, 1950; Strupp, 1955; Dickenson and Truax, 1966; Truax and Carkhuff, 1967). There is general agreement that age, sex, and the level of experience of coun-

selors, as well as self-presentation to the client, are important factors in therapeutic counseling. The literature on the group counseling of underachievers, however, is generally negligent in reporting such variables. This writer was unable to locate even one study on the group counseling of underachievers in which the first three of these variables were specified, while most reports provided data on only one or two. Several studies described using counselors with various levels of experience, and several others reported that the counselors had limited experience or no experience at all in any sort of group counseling. Studies have reported using group leaders who were certified school counselors, Ph.D.'s in clinical and counseling psychology, ABEPP diplomates, and persons with extensive experience in both group and individual counseling and psychotherapy (Laxer et al., 1966; Spielberger and Weitz, 1964). No studies have given full recognition to the effects of counselor sex, although an unpublished paper by Herrold et al. (1968) suggests that female counselors may be somewhat less effective than male counselors when working with male high school underachievers. Only one study was found (Dickenson and Truax, 1966) in which the qualitative aspects of counselor-produced stimuli and therapist-offered conditions were considered as independent variables affecting counseling outcome. At the risk of sounding redundant, the published research on counselor variables in the group counseling of underachievers is, at best, almost nonexistent.

CONCLUDING REMARKS

In view of the inconclusiveness of the literature on the effectiveness of group counseling with underachievers and the many methodological problems revealed by a review of the published literature, it seems appropriate to attempt a brief integration, synthesis, and extension of the material that has been discussed by suggesting what seem to be promising directions for future study.

As suggested earlier, it appears necessary that research be conducted with behavioral modification techniques for treating underachievers. Although research on the behavior therapies is presently limited in scope, its success in both individual and group settings bodes well for its use in dealing with the problem of underachievement. Studies might be conducted in which comparisons are made between the effectiveness of

desensitization techniques and verbal conditioning techniques, for example, in improving the academic performance and behavioral change of underachievers.

As was pointed out, leader-structured groups appear to be the most effective group method for the counseling of underachievers. If this is so, and the evidence in this regard is not yet clear, it implies that insight, as it is defined by psychoanalytically oriented counselors and therapists, is not essential to the successful treatment of underachievers. This should be verified by comparing the effectiveness of cognitively directed, goal-directed, and problem-solving groups with more purely interpersonal techniques such as sensitivity training groups.

These suggestions strike the writer as two potentially fruitful approaches to the group counseling of underachievers. The more traditional approaches to this problem have proved themselves to be inadequate for dealing with what is one of the most intractable and perplexing problems in our modern educational system.

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Group Psychotherapy with Psychiatric Residents

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A PERSONAL EXPERIENCE IN individual psychotherapy is considered by many educators to be an essential element in the training of psychiatric residents who plan to practice individual psychotherapy. Such an experience sensitizes residents to psychodynamic processes in themselves and in the patients they will be treating. In addition, it enables them to overcome their own personality problems, real or imagined. However, until relatively recently, the development of adequate training programs in group psychotherapy on the residency level have lagged behind those programs available for training in individual psychotherapy (Sadock et al., 1968). The authors feel that it is equally beneficial for those who wish to practice group psychotherapy to have a personal group psychotherapeutic experience so as to become sensitized to various group dynamics and to benefit therapeutically.

This paper will report on our experience with the program at the New York Medical College—Metropolitan Hospital Center, where all psychiatric residents have, for the past several years, been offered intensive group psychotherapy on a long-term basis as part of their three-year residency program in psychiatry. We will discuss the implications of this program in regard to the training of residents in general psychiatry and in group psychotherapy.

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DESCRIPTION OF THE PROGRAM

Unlike the few other programs that afford residents an opportunity to participate in a group experience, where the time and depth of participation is generally limited, the program at our center extends throughout the entire three years of the psychiatric residency (a total of approximately 150 hours of group psychotherapy for each resident). The program is presented as a therapeutic group rather than as a "training group" or "sensitivity group" as is done in certain other centers, and we feel that the time allotted for this therapeutic experience is sufficient to insure member involvement, in-depth examination of psychological processes, and eventual therapeutic progress.

The psychiatric residency program at our center is large; each year we admit an average of 15 to twenty residents. The group psychotherapy experience is outlined to new residents during their first week at the center. Participation, of course, is not required of all residents since the program is therapeutic and therefore must be voluntary. During the second week, regularly scheduled group sessions begin and continue for the next three years. The groups are coeducational and the resident progresses through first-, second-, and third-year groups, according to his level of training. A resident who enters the program in midyear is placed in a group corresponding to his level of training.

Once the resident has chosen to participate, he enters into a therapeutic contract. He agrees to be frank and truthful about his thoughts and feelings, and to examine any resistance he might have toward what is expected of him as a group member. He agrees that all aspects of his behavior may be examined when appropriate. The group members and the therapist observe the strictest confidence as to what is said in the group, in accordance with the medical ethic of the confidential relationship between doctor and patient. The therapist does not take part in administrative decisions which may involve residents he treats in groups.

Originally it was planned that the program would run for only one year, but the residents themselves asked that the program be extended through their full three years of training. Feeling the group therapy experience to be of value, the residents have been overwhelmingly in favor of the program. One resident, having been drafted into the armed forces, requested to attend the group sessions during his infrequent trips back to New York. Another asked to continue as a member

of the group after he had transferred to another psychiatric residency in the New York area. Since the program's inception about ninety per cent of the resident population has participated in it, and the dropout rate has been less than ten per cent, which is well below that usually reported in group psychotherapy studies.

STRUCTURED INTERACTION

The residents' approval of the program and the low dropout rate are, we feel, positive and significant, reflecting both the population involved and the method used. A coauthor of this paper (H.K.) originated, practiced, and refined the psychotherapeutic method called "Structured Interaction." It has been utilized since 1953, and departs from established techniques. Certain modifications were necessary in applying the method in groups composed of psychiatric residents, who are relatively more attuned to therapeutic practice; but there remain marked similarities to the way that the method is applied in less specialized groups.

The structural matrix of group interaction is based upon the introduction of several specialized procedures, some classical and some innovative, which are designed to intensify the group experience and to allow the therapist and the group members to examine thoroughly both group and intrapsychic group dynamics. In order to insure that each member of the group participates, a different member of the group becomes the focus of the interaction on successive weeks. The therapist may choose a particular member, or a member may request that he be the center of discussion during a session. The members do not know in advance who will be discussed, and eventually the entire membership is covered, at which point the process is then repeated. Thus, every group member is compelled to participate and no one is allowed to withdraw. This is the most important of the specialized procedures that is utilized in the structured interaction method.

The role of the therapist is unique within the group; he is at the same time both part of the group and apart from it. He does not participate in the same sense as do the group members, even if the members ask him to. Rather, his involvement is indicated by his interest in the group, his attempts to monitor the anxieties of a member of the group or of the group as a whole, his interpretations, and his concern. As Parloff (1968) has pointed out, the "therapist by becoming a member

of the group may be restricting his effective role to the point where he slights or minimizes unique contributions which he can make on the basis of specialized skills and areas of competence not otherwise available to the patients."

The therapist is a participating observer, and as such he himself must have no need to receive therapy from the process. Naturally, it will enable him to know and to understand what the residents are experiencing if he has been through a similar experience himself; and having had a similar experience he will also have attained, hopefully, sufficient self-awareness and objectivity so that problems of countertransference do not interfere with his ability to conduct this type of group. As Freud (1910) wrote, "We are bound to insist that the psychiatrist recognize countertransference problems and eliminate them." If the group leader is to teach others to recognize and eliminate countertransference problems in their work with patients, he must already have accomplished this himself, so that, with his specialized skills and training, he may remain separate enough to observe the group and his own feelings.

The group leader determines the behavior of the group by supplying the structural matrix and by deciding on the areas to be explored by the group, the timing and content of sessions, and so on. The leader is in control of the group, and there is some indication from small-group research (Berkowitz, 1953) that there is a relationship between cohesiveness (which is high in our groups) and the degree to which the leader fulfills the role expectations of the group members.

TECHNIQUE

The first session is devoted to an autobiographical "go-round." Each member gives a brief sketch of himself, describing his character structure and his major problems as he sees them. The degree of awareness and openness manifested in these sketches varies greatly. One member may simply set forth the factual data of birth, marital status, and so forth, while another may go into a detailed analysis of a particular personal problem. Generally, the resident group has a higher level of insight and psychological sophistication than a group of laymen. In one characterologic "go-round," one resident started off by describing himself as being "paranoid and angry," and indeed this was the case. Another

member of the group described herself accurately when she said, "I am anxious and blocking."

As might be expected, the character sketch is rarely a true picture. The resident wishes to see himself—and wishes others to see him—in a particular way, and his perception of himself is therefore likely to be distorted. In the first session, one resident described himself as having a violent temper when frustrated. In a later session he was reminded of his earlier statement when the group was discussing his extreme passivity. What is omitted during these character sketches can often be as important as what is stated, and the manner in which it is presented can also be of significance. Another resident said during the first meeting, "Oh, yes, I'm married, too." The statement was made as an afterthought. Then in the sixteenth session, the resident began discussing his extramarital affairs and related problems.

The residents have an opportunity, during the time of the character sketch, to inform the group and the therapist of those particular problems with which they genuinely feel they need help. One resident, who later explored with the group the feelings associated with being abandoned by his parents, had begun by saying simply, "I hate my father." Another said he sought help in dealing with an obsession he had about going blind.

In the early meetings, following the first "go-round" the emphasis, in general, is on commonalities rather than differences, the object being to increase the cohesiveness of the group. A member who finds similarities between himself and another is urged to discuss those common experiences, whether it be on the level of simple autobiographical fact, such as being an only child, or on the more complex symptomatic level of, for example, being withdrawn. Through questioning each other, probing and seeking clarification, the members begin to get to know one another. The therapist then begins choosing members who will be discussed, and when the members themselves become secure enough in the group situation, they begin volunteering to be the focus of discussion. The therapist's choice depends, among other things, on the anxiety level of the individual group members. Having gauged this, and having made a clinical judgment based on his perception of the residents, the therapist chooses, in the early meetings, to focus on those members who are showing the least amount of overt anxiety. Those with a higher level of

anxiety would feel too threatened and would tend to withdraw. After the more anxious members have had an opportunity, over a period of several weeks, to develop a supportive, dependent relationship with the other members of the group and with the therapist, they may begin to feel more comfortable and open with the group. If this does not happen, the group will examine the reasons when the member is ultimately focused upon.

The area to be explored may be chosen by the member being focused upon, or it may be suggested by the therapist based upon his knowledge and perception of the member. Any area of the resident's life may be discussed; he may be probed for further information, pressed on inconsistencies, or have his remarks interpreted by other members of the group or by the therapist. As was mentioned earlier, part of the group contract is that the members agree that such free discussion will take place.

During part of the discussion it may be suggested that the member being focused upon listen while the group members state their positive or negative feelings about him, thus providing him with feedback from his peers. This technique is used to work through interpersonal difficulties, which develop more quickly in resident groups than in conventional psychotherapy groups since the members come into daily contact in the hospital. Residents will often wait until the group session before confronting one another. The group provides them with an objective viewpoint as well as the support of the therapist. The thoughts and feelings of the members of the group are, naturally, both rational and irrational; but, in general, group consensus is remarkably accurate. Where inaccurate, the opportunity is provided for exploring the basis of a particular misperception.

Videotape is also introduced into the group within a structural framework. Among several methods used is one in which each member is asked to fantasize about his body image while being taped but without being able to view the monitor. During playback, the discrepancies between his fantasized image, which includes body configuration, mannerisms, transmitted anxiety level and so on, and his actual image as portrayed on the monitor is compared. Each resident contributes to the others' observations, and the psychologic significance of the image impact is examined.

THE FIRST- TO SECOND-YEAR TRANSITION

Group psychotherapy sessions for the residents at our center have given us the opportunity to observe several interesting phenomena relative to the residents' overall training. Initially, residents are eager to participate in the group and show great enthusiasm concerning the group leader and the methods used. The leader is viewed as all-seeing and all-knowing. The sessions are generally productive.

Group rebellion begins to occur, however, at about the time the members are making the transition from their first to second years of residency, that is, at about the thirty-fifth to forty-fifth sessions of the group. Residents begin confronting the group leader, criticizing his interpretations or techniques, and challenging his competence, his training, background, and his personal characteristics. In short, everything about the formerly "omnipotent" group leader is now open to question.

The rebellion phase in group situations parallels the rebellion that occurs, generally, among residents during their transition from first- to second-year status. The eagerness and enthusiasm of the first year is followed by the dissatisfaction, the persistent complaints, and negativism of the "second-year slump," which has been described by Holt (1959) of the Menninger school of psychiatry in his study of the personality growth of psychiatric residents. Similarly, Hammet (1965) discussed the "troublesome feeling of futility which threatens the resident's peace of mind at about the time of his second year of training." One possible explanation is that the resident becomes frustrated and discouraged when he begins discovering that there are inadequacies and limitations in the theory and technique of treating mental and emotional illness, and the teacher who was once looked to as the source of all knowledge in this area now becomes the object of resentment and hostility as a result of his "betrayal."

This experience occurs in other settings as well. Astrachan and Redlich (1969) discuss the process of group revolt and the concerted attempt by the group to "overthrow" the leader. A resident group studied by Kamin (1966) went through a similar phase in which it was suggested that the format be changed and even that "meetings be held in a bar." In their training, psychiatrists are bound to be affected by the recognition that there are limitations in the body of psychiatric knowledge and that their teachers are human and questioning instead of omnipotent

and omniscient. The resulting feelings of disappointment and distress, and the phase of group rebellion that accompanies these feelings, can be resolved when there are means to facilitate appropriate intervention. The structured interaction technique gives the residents an opportunity to work through their rebellion. It provides an outlet for the individual to express his angry feelings toward authority while keeping the process of group contagion under control and thus preventing total rebellion. By focusing on particular members, it allows for the intrapsychic reactions of the individual to be examined in depth.

While we agree with Holt's hypothesis concerning the second-year rebellion, we have also had an opportunity to observe a previously unreported phenomenon which also accounts for the difficult transition from first- to second-year resident status. In the early meetings of the second-year groups, it becomes evident that the residents have developed intense feelings of rivalry toward the new first-year resident group. In our residency program, as in most, the first-year residents are subject to an intensive orientation period under the tutelage of senior faculty members. The second-year residents no longer receive the same care and attention. This situation is disappointing and frustrating in itself; but the second-year resident becomes aware also that the therapist, toward whom he has developed various transferential feelings, is now giving his attention to the newcomers as well—to the new siblings in the family. Having to assume new responsibilities without any special orientation program, having to share faculty and therapist with the first-year residents, and finding no apparent concern for his feelings outside of the group experience, the resident becomes anxious about entering his second year and resentful toward the first-year students. All this, as well as the rebellion phenomenon already discussed, makes this transition period a difficult one for the resident; but we believe we are reporting for the first time a way in which this can be worked through effectively.

THE THIRD YEAR

During his third year of training the resident has the opportunity to develop and consolidate his identity as a psychiatrist, but it is an identity not easily developed. Expectations of the resident in his third year are high. He is expected to act in an adult manner, yet at the same time he is subject to continued teaching and supervision. The latter carries

with it the message that there is still much to learn. And, indeed, the resident himself is generally uncomfortably aware of this as he realizes the limitations of his effectiveness. At first, his awareness expresses itself in another rebellion against the group leader, who is seen as a representative of the "Establishment." The group technique itself comes under attack, and rather than structured interaction the residents begin demanding spontaneous interaction in the group. And, indeed, the therapist does well to relax the structure of the group during this period and so begin the process of termination. It is necessary, however, to first interpret the members' request for greater spontaneity to prevent the members from fighting for leadership among themselves. At this stage, the therapist may be viewed as an intruder whom they must exclude. In effect, the members are saying that they are in their third year, they will soon be treating patients on their own, and they no longer require the direction of the structured interaction technique.

An effective method of diminishing the central role of the group leader and an aid to the working through of the conflict between the residents' demands to be treated as trained clinicians and their desire to be treated as students with dependency needs has been developed. In brief, this is achieved by having each member, in turn, responsible for conducting a particular session in any way he sees fit. By so doing, the struggle for leadership diminishes and the therapist is not actively excluded; rather, as the group becomes conscious of its need for help in certain situations, the therapist is allowed to be active and to exercise his expertise.

During the final phase of the group, the therapist functions primarily as an adviser. Structured interaction is no longer used as a primary technique but only as the residents choose. Spontaneously and without specific direction by the therapist, a member will bring up a topic that is meaningful to him for examination by the group, which finally functions independently with the members acting as psychiatrists for one another.

DISCUSSION

As mentioned, the dropout rate is extremely low. When a dropout does occur, the resident is, in most cases, in individual therapy, although this is not usually the sole reason for his leaving.

For the majority of the residents in our program, the groups were

their first therapeutic experience. Forty to fifty per cent of the group members entered individual therapy by the end of their first year of training. Dropouts sometimes occurred when an analyst had objections to his analysand being in the group or when the resident expected more from the group than the group could realistically offer. There were also some residents who were oriented toward a classically psychoanalytic method and who felt that individual therapy offered them a greater opportunity to examine the transference relationship to the therapist.

The psychotherapeutic benefits to the majority of residents have been extremely significant. A great variety of psychopathology and behavioral patterns are observed in the group. At no time, however, did the group process precipitate or aggravate emotional problems. On the contrary, it often enabled us to identify difficulties early which could not be dealt with in great enough depth in the group and a resident was then urged to enter individual therapy. At times, an individual session might be held with the group leader, but no regular individual work was carried on by him with any of the members.

In any psychiatric residency program the "second-year slump" may disrupt the entire program as well as the residents' personal equanimity. Disillusionment may cause a resident to withdraw from the program entirely with the purpose of finding a center where he will be provided with a more systematic theory of human behavior; or it may cause him to enter formal psychoanalytic training in hopes of finding an approach to the problem of mental illness that to him seems more logical, coherent, and authoritative.

Leaving a training center or entering psychoanalytic training can, of course, have rational justifications. But these decisions will be ultimately unsatisfactory to the resident and to the entire training program when the course of action is an attempt to avoid the dilemma of therapeutic futility or the realization that there are large gaps and inconsistencies in the psychiatric body of knowledge or when the purpose is to achieve an "emotional lift."

In the personal group psychotherapy experience, the vicissitudes of the resident's personality growth can be resolved, and if he chooses to drop out of the program or to enter psychoanalytic training, his choice is usually a career decision based on realistic considerations. And, finally, the trainee who is a member of a psychotherapeutic group increases his

competence as a psychiatrist and as a group psychotherapist. He has an opportunity to develop a greater self-awareness and a greater understanding of the human condition. He increases his ability to understand others and to make himself understood, and at the same time he develops a deeper appreciation of the therapeutic task he sets for his patients.

SUMMARY

All residents at New York Medical College—Metropolitan Hospital Center have an opportunity to participate in a psychotherapy group as part of their three-year residency training program. The psychiatric residents who comprise the groups are each provided with approximately 150 hours of personal group psychotherapy. The dropout rate is under 10 per cent, and this low figure is closely related to the structured interaction technique that we employ. This technique of group psychotherapy involves the creation, by the therapist, of a structural matrix within which the group members interact. The resident is provided, via the group experience, with a way of understanding his own emotional problems and those of others. The group experience also helps to ease the transition between the first and second year of the residency when disillusionment and personal disequilibrium may result from recognition of the limitations in psychiatric knowledge. And it provides the resident with valuable training for future practice as a group psychotherapist.

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Leadership Ambiguity and Its Effect on Residents' Study Groups

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An IMPORTANT GOAL OF residency training programs is the facilitation of the trainee's ability to listen on multiple communication levels and to respond appropriately to selective aspects of communicative behavior. The resident should learn how an individual's experiences modify his thoughts and behavior in order to learn how to attend to a patient's many messages.

Within the group setting the trainee can transact on a number of communicative levels and experience a diversity of interpersonal relationships. The small group also serves as a convenient setting in which authority relations may be studied. The "study group" (Rice, 1965) was chosen as the primary group learning experience for trainees in our department and for the past three years has been a required part of the resident psychiatrists' curriculum.

Groups of 11-13 members each are formed for incoming psychiatric residents, psychologists, social workers, nurses, occasional chaplaincy residents, educators, and hospital administrators. All members of the study groups receive a letter which conveys information about the meeting place and the time of the meeting of the groups. This letter also attempts to define the work of the group: "The purpose of these sessions is to provide the members with opportunities for increasing aware-

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ness and understanding of intragroup phenomena. We will focus especially on the covert processes which operate in and among groups. The faculty members, who act as consultants, are concerned not with individual personality but with group behavior, and particularly with the elucidation of the unspoken attitudes and behavior patterns which so frequently distort group thinking and impede effective group action. Thus, the primary objective of the meeting is the study of behavior in groups rather than group therapy for the individual members. The task of each group is to study its own behavior in the here-and-now. The consultant's task will be to help the group examine its own behavior." An attempt is made to keep group members fairly homogeneous in regard to age and level of experience.

The theoretical underpinning of these groups draws heavily on the work of W. W. Bion (1961) who has tended to focus his theories about groups on the relation of the group to the leader and has evolved theoretical constructs which define some of a group's expectations of leadership. The groups are designed to function in such a way as to make apparent Bion's constructs. The study group consultant attempts to define his own boundaries carefully and to maintain his separateness from the members. He can, however, only function effectively if he is in the group sufficiently to share in the common feelings and attitudes. Being separate enough to observe the group, himself, and his feelings, he can investigate his impact on the group. He has no political power to lead the group, save the power that resides in the members' fantasied expectations of him. His leadership comes from his definition of the group task and his devotion to this task. By insisting upon his separateness and his freedom from the group in order to pursue his work, he establishes himself as an ambiguous leader who rejects political power but whose every utterance stimulates the recognition of his separateness and leadership.

He defines constraints on his own behavior, and the group begins to assume that he defines its behavior. For example, he arrives promptly and leaves promptly. The group within two sessions begins meeting promptly with full attendance, and lateness becomes an important group issue.

The complex interrelationship between the concepts of authority and leadership are evident here. Authority is most frequently defined in terms of "power" or the "right to enforce obedience," and it is associated with the "right to command or give an ultimate decision." Leadership is

usually described as "guiding or conducting," and the tasks of leadership are related to achieving goals. Within the study group, the consultant whose leadership is not clearly defined becomes a focus for fantasies about authority, and questions about his "power" become paramount.

In the first group meeting his behavior implicitly defines his relationship to the group, and the group assumes that this definition establishes his authority. He behaves as if he knows what he is supposed to be doing in the group, and throughout the sessions he attempts to attend to his task. The members of the group are far less sure of their roles and the consultant rapidly becomes the focus of the group. Yet, the consultant's behavior is not that behavior usually associated with concepts of leadership. He leads in the sense of attending to his assigned task, but this is independent of the consent of the group and he has no real power to coerce others to attend to the task, nor does he lead by force of personality or even by his ability to focus on dangers which might face the group. At times he may even directly eschew "leadership," as, for example, this statement made in one such group: "The group persists in calling me a leader. I am here as your consultant."

The members initially experience the group as being a threat to their wishes to remain separate individuals because of the group's seductive pull to be part of a mass. The individual within the group is able to become somewhat more comfortable about being in this new setting by elaborating fantasies about the power of the consultant. However, as the consultant continues to focus on the group's expectations of him, rejecting political leadership (authority) while asserting by his actions his leadership in task performance, the group often enters into a stage of intense competition for political leadership and power. This competition may involve elements from a variety of intragroup and extragroup sources. One's social or sexual role can be used as a way of seeking or rejecting leadership, as the following comments exemplify: "Psychologists don't have to worry about leading. They can sit back in sport shirts and look at what goes on." "Why do doctors think they can speak directly to God?" "I would never fight for leadership; it just isn't feminine." This statement by a relatively passive male, "I don't want to lead, I just want to be well liked," was immediately followed by an attack from the women in the group. Such strivings are often unrecognized by the members. For example, in a study group of historians, during an intense, unacknowledged battle for leadership, the most active member was caught

in a "slip" about wishing to lead and responded by noting that as an educator his function was "to lead forth" (from the Latin, *educare*), and he wished no "other form of leadership."

The development of a "sense of group" can be studied during this phase. Boundaries become defined not only by the consultant's behavior but by the members' expectations of the consultant and one another. In order to cope with the consultant and the intense strivings for leadership, the group early in its history begins to define normative behavior, and members are able to examine the conflict arising in almost all of them between the need to belong and the wish to be separate, the danger of being isolated and the panic at being engulfed. To deal with the demands of this situation, the members must begin to come to grips with one another, to define their relations to each other. A variety of roles are utilized to begin to define how an individual serves the group and can be even minimally apart from the group. As the consultant interprets the roles, he reinforces his separateness and places the group members back in the group. His behavior obviously makes him unique, for as he becomes separate from the group, he also insists upon his membership in the group since he cannot make a valid interpretation unless he has obtained his evidence from being in the group. The members' response to this behavior is to begin to insist that they will allow no other person to separate and be beyond the group.

The group is placed in an intriguing bind in regard to the consultant. He says with almost every comment, "I am both in and outside of the group." The members' response is most often to reject one part of this statement and either to accept the consultant as part of the group ("He really is on the ball.") or as being outside the group ("Every time he opens his mouth he interrupts what we are doing."). Yet, either of these responses to the consultant ignores the other side of his communication. Note, for example, this dialogue involving seven different members of a study group, which followed the direct expression of anger toward a consultant:

1. "I am angry! [In this situation] I can feel more comfortable about him [the consultant] than myself."

2. "He [the consultant] sets this up. He said the group gets angry at nonparticipant members, and we've been talking about him ever since."

3. "He doesn't participate, Old Rock Face."

4. "He's smiling inside, but he doesn't respond."

5. "How can you say he doesn't respond when his comments reflect his interest?"

6. "He listens intently but acts like a deaf mute. He's not spontaneous, not a member of this group."

7. "When we compare ourselves to him, we define membership."

A group member would have to communicate at a higher level of abstraction (Watzlawick et al., 1967) to deal with both sides of the consultant's comments at once, but were he to do that, he would be assuming a boundary or leadership position within the group, and that communication would be viewed in the group as a bid for leadership and would be rejected by the group.

The group often unites in a very cohesive manner, establishes group norms and group consensus, and then either attempts to seduce the leader into the group or attempts to overthrow him. In one group the consultant was referred to as an "old walrus" who frolicked with the young pups but might be overthrown by "the young bulls" or just left aside on a lonely rock. In this process, groups may examine the processes of group revolt, group power, and the manner in which legitimate succession is established (Slater, 1966).

The focus on the behavior of members as a derivative of relations to the leader stresses group phenomena somewhat at the expense of individual phenomena. Additionally, group behaviors occurring among peers are difficult to study in this setting, since the focus on the leader stresses the relation of the group to leader (consultant) and the relation of individual group members to him. The relations of member to member are often seen as derivatives of the relation of members to leader, and issues of choice among members for one another's regard, affection, etc., may be hidden in extragroup behavior in order to avoid confronting both the realities of the situation and the fantasies about the consultant's response to such interaction. In such a group it is possible for a member to reject the other group members but remain ambivalently tied to the group and consultant. "None of you are important to me. I want something out of this group, but I don't really need any of you." Such individuals may be scapegoated by the group or even (rarely) assume positions in which they seem to scapegoat the group. The "filling-up" of a scapegoated member with the affects of other members is often demonstrated, as is the continuing importance of the scapegoat to the group. In a group in which one member had been repeatedly set apart from the group, another

member arose during a session and traced a circle around the group which excluded the scapegoat from the group yet maintained him in the room as an "impotent critic." The participation of the scapegoat in his own persecution can be examined, as can the reason for the selection of a particular scapegoat. It is not unusual in such groups for one member to be maligned in the group and yet to attend faithfully even when isolated in the group, with the group also insisting on the scapegoat's presence although they claim they would wish him gone. The consultant, while such a situation is occurring, is ineffective in his work, for although he attempts to help the group examine its behavior, the group is usually uninfluenced by him. Later the group may malign the consultant for being an ineffective leader, but hopefully the group will learn something about the interrelations of members and leaders and how responsibility in a group must be shared.

Since such groups are finite, the group also has the opportunity of examining issues relating to the death of the group and the tremendous power of a group to perpetuate itself. During the work of termination, members often focus on the similarity of group termination to important themes in their own lives. One member movingly noted how the petty anger in the group reminded her of the viciousness of dying parents and dying patients. Another member, in a different group, described the loneliness of separating out of one's group of origin, moving on to other groups, and sometimes, like the consultant, alone outside the group, committed to a type of work, yet longing to be back in the group, part of the group.

A number of residents noted that the consultant's behavior served them poorly if they tried to behave as the consultant did in groups in which they had a therapeutic role. "The study group helped me understand better what happens in groups, but such (leadership) passivity and ambiguity doesn't help psychotic patients."

In our work, we have frequently been asked whether such a group experience activates psychotic behavior in some individuals. Resistance to such groups often focuses about this issue, to which there is no easy answer. Painful experiences may be evoked by the group, and, obviously, the individual experiencing fantasies within the group will experience these fantasies intensely and personally even when they originate in shared group life. In our groups, however, although several members

have described themselves as having been upset, we have not seen any psychotic behavior.

The interest stimulated by the group training exercises has led to the development of an interdepartmental seminar on groups at Yale. The members of this seminar are involved in examining training group models. The development of viable theory is ultimately dependent upon experimental validation, and the interdepartmental seminar currently is examining the relationship of the study group to the T-group and attempting to assess the advantages and disadvantages of these pedagogic tools experimentally.

Over the past several years we have interviewed many of the participants in the study groups in order to develop some tentative ideas about the value of the program. Psychiatric residents have described the study group experience as particularly significant for them as an introduction to organizing their experiences in groups. One resident commented that, "It was like reading about the unconscious for the first time. Group phenomena are real; they must be reckoned with and understood whether one likes the idea or not." Some residents have remarked that, upon entering the residency program, they are to some degree comfortable with individual patients because their expectations about psychiatric training very much include seeing patients in individual sessions; however, they are generally unprepared to observe individuals in social settings and feel confused by hospital settings which focus on the individual's relation to the social setting. The group training program provides them with the experience and vocabulary (Redlich and Astrachan, 1969) necessary to their beginning to learn about the impact of social settings on the individual.

Over half the residents interviewed volunteered the information that they felt more confident about their own observations of group behavior after this experience, and almost all noted that the work of these groups helped them to understand better fantasies about authority in groups.

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Using Encounter Group Techniques in the Treatment of the Social Network of the Schizophrenic

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DURING THE LAST FEW years, attempts have been made to introduce a variety of sensitivity training techniques in the treatment of psychiatric patients (Rothaus and Morton, 1961; Morton et al., 1961; Rothaus et al., 1963; Malamud and Machover, 1965; Barthol, 1968). In most instances the results indicate that sensitivity training can provide a meaningful and beneficial experience to patients, can serve as an aid in future therapeutic interventions, and can provide a stimulus for change in the patients' perceptions, feelings, and behavior.

Speck and Morong (1967) have defined a social network as that group of persons who maintain an ongoing significance in each other's lives in terms of fulfilling specific needs. In the past three years, Speck has treated 14 social networks, each representing the family, friends, and neighbors of an index schizophrenic person. Speck has used the term "network therapy" to describe this innovative approach.

Speck and Rueveni (1969) report their experiences in working with the social network of a family containing a labeled "schizophrenic person." Seeking a therapeutic approach which would be effective in modify-

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ing the strategy of a schizophrenic person, forty network members consisting of the immediate and extended kin, neighbors, and friends of the "schizophrenic person" were assembled. Six four-hour social network meetings were conducted, using a variety of sensitivity training techniques. Results indicate that the social network meetings were successful in modifying the relationships between the schizophrenic person and his family, providing a viable social structure for continuing encouragement, support, employment, and avoidance of hospitalization.

In the present paper an attempt is made to describe briefly what network therapy is by focusing on several basic encounter group techniques (sensitivity training) used during a six-week stint of social network therapy.

GOALS AND RATIONALE FOR NETWORK THERAPY

The major goal of our approach is to alleviate a crisis situation in a family, although, at times, our goal may be the opposite one of creating a crisis where there is insufficient pressure toward change in a malfunctioning family system. We aim at preventing hospitalization, and instead, providing the troubled family with a group of concerned human beings, consisting of the family, their kin, friends, and neighbors (the social network) who are willing to give emotional support and create therapeutic potentials for healing.

We subscribe to the hypothesis that decreased rates of mental illness often result when a person has a large social network actively intervening in his life. By convening the social network of the schizophrenic person and his family, we are reconstituting a forgotten and often hidden group of relationships, with the purpose of making the entire group as intimately involved as possible in each others' lives in order to supply a strong sense of "tribe" support, reassurance, and solidarity.

Our approach aims to create within a brief period of time (six weeks) a potent therapeutic climate within the social network. To achieve this purpose, we have utilized a variety of encounter group techniques to facilitate the expression of honest feeling and openness in interpersonal communication and the development of trust between "tribe" members. We have sought to create conditions conducive for the index patient in the network to modify his patterns of behavior.

We have found that encounter techniques, even in large groups, can

stimulate rapid jelling of the assembled social network into a cohesive, task-oriented group. Interpersonal defensive operations are more rapidly discarded than when conventional group psychotherapy techniques are used. The development of trust between group members seems to be enhanced, opening the way for innovative activism. By using encounter methods, the network therapists feel they can prepare the group to intervene, take more risk, to care, and to give of themselves more readily. The network members themselves determine what the network tasks are to be in order to break up tight and chronic symbiosis and motivate an unemployed schizophrenic person to work or a house-bound person to move out into the world.

TECHNIQUES USED

In recent therapies of two social networks, we have found the following techniques useful.

Inner-Outer Group Encounter

Members are asked to assemble in two concentric groups. Members of the "inner circle" are directed to interact while members of the "outside circle" observe and refrain from speaking. Every twenty minutes the groups change, and members of the inner circle move back and sit in the outside circle. Members of the outside circle can comment or consult with the members of the inside circle only if they take a seat in an empty chair in the inner circle. This is called "the consultant's chair."

We have used this method primarily during the first two network meetings as a method of rapidly acquainting network members with each other and at the same time pulling them together as a group with a task. The tasks for inner group members is varied. Members are asked to give their impressions of each other and then to discuss their feelings. They are asked to role-play, to assign names to various group members according to their feelings at the moment about those persons, and to share their feelings with regard to the tasks. We usually ask members of the outside group to comment upon what has happened in the inner circle. We have found that splitting the "tribe" into two concentric groups with different assigned tasks produces an increase in group tension. We feel this is desirable in the process of tightening the network. The two groups become critical and competitive, thus generating increased ten-

sion which leads to deeper interpersonal involvement and network commitment. When the tension between the two groups becomes unbearable, cohesiveness of the whole network is facilitated. They unite as in religious conversion and share a feeling of oneness and closeness. We have called this process "synthesis."

Eyeball-to-Eyeball Confrontation

In this exercise, originally described by Schutz (1967), two group members are instructed to remain silent, look into each other's eyes, and walk very slowly toward each other. When they get close to each other, they are instructed to do whatever they are impelled from within themselves to do. We find this technique particularly useful in encountering the labeled schizophrenic person with his father, mother, sister, and friends. For example, a daughter first approached her mother very hesitantly, then later she hugged and kissed her. This was particularly interesting since they had never been able to do so previously. Such encounters stimulate an intense exchange of feelings among other network members and enhance the climate of trust in the entire group.

We feel that the blocking of verbal communication forces the members to search for new modes of communication, which is part of preparing the stage for change to occur. Nonverbal communication modes are more primitive and probably reach deeper into the person, allowing sudden emotional outbursts as well as making him aware of interpersonal needs for contact, affection, love, and care.

Breaking "In" and "Out"

Members of the group form a tight circle, interlocking their arms. The schizophrenic person stands in the middle and is instructed to break out of the circle. When this is accomplished he has to break into the circle again. This can be one of the most dramatic moments in the entire social network meeting. Ann, for example, had expressed her feelings of disgust with the entire meeting, characterizing the group members as being superficial, hypocritical, and unconcerned about her. She was asked to name those individuals she blamed most, and they then formed a tight circle around her. It took her ten minutes of hard work to break out of the circle, and she was crying and exhausted. She struggled, pulled, kicked, and hit members of the circle the entire time. When she accomplished her task (first breaking out, then breaking in

again), each member approached her and expressed his feelings toward her. Many hugged and kissed her. During the ensuing discussion, Ann and the group felt close to each other and a productive exchange of feelings developed.

Group Swaying

An entire assembled network of, say, seventy persons is instructed to hold hands and then to close their eyes and begin swaying. After a few minutes of silent swaying, the members are instructed to express in one word whatever they are feeling about the schizophrenic person. Affectively tinged associations rapidly spread throughout the group. Such things as care, concern, hope, love, tension, fear, despair, joy, sadness, confidence, and trust are expressed. The swaying and the nonverbal union by hands produces a type of group conversion experience and a oneness with each other.

In our McLuhan world of instant "tribe," many humans feel their isolation, loneliness, and alienation. There is a hunger and longing for touch, closeness, group inclusion, and belonging. Group swaying can meet some of this deep human longing. The numerical increase and success of group marathons using encounter techniques attest to a general seeking in our culture for a return to the mystical and religious type of experience rather than the purely verbal. Swaying seems to have potential in meeting more primitive group needs.

CONCLUSIONS AND IMPLICATIONS

Our experiences in conducting network meetings increased our confidence that many encounter group techniques can enhance the therapeutic potential of the social network of the schizophrenic person. We feel that the social network can provide a possible alternative to hospitalization in many cases. We find that by utilizing encounter group techniques we can enhance conditions that provide the schizophrenic person and his family with group support and trust. In two recently completed networks, our aim was to help the schizophrenic person separate from his family, live independently, and seek employment. In both cases this was accomplished. We are currently planning additional social network meetings in an effort to improve our techniques and utilize crisis situations that can be benefited by social network assembly.

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Multiple Family Therapy: The Interaction of Young Hospitalized Patients with Their Mothers

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MULTIPLE FAMILY THERAPY HAS recently evolved as a logical extension of group and family therapy techniques (Curry, 1965; Davies et al., 1966; Hes and Handler, 1961; Kimbro et al., 1967; Levin, 1966). Extensive investigation of the single family unit has provided the basis for most of the current literature on family process and schizophrenia. In general, different aspects of the problem have been stressed by different investigators. For example, the importance of distorted communication in schizophrenogenic families has been particularly emphasized by Bateson and his co-workers (1956). Such "double binds," as they are called, occur primarily between mother and child and produce unresolved conflicts in the child from which the only escape becomes the schizophrenic solution. The Bateson group (Jackson, 1957) has also stressed the concept of a "family homeostasis" by which improvement in the "identified patient" may result in another family member becoming sicker.

The Lidz group (1957, 1960) has focused more on the etiologic significance of disturbed role relationships within the family in contributing

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heavily to the dynamics of schizophrenia. Such pathological role relationships may take place between parents and child, as in the blurring of generation lines noted by Lidz and Fleck (1960), or between the parents themselves, as in "marital schism" and "marital skew" (Lidz et al., 1957).

Wynne and his group (1958, 1961) view schizophrenia as resulting from internalization by the offspring of deviant behavior patterns inherent in the family structure itself. In such a pathological family setting, experiences tend to be fragmented, perceptions and communications become disturbed, and the child's identity remains diffuse and disorganized (Wynne et al., 1958). Two of the more insidious ways in which reality becomes denied or distorted are via "pseudomutuality" or "pseudohostility." The former may serve to keep negative feelings unexpressed, whereas the latter may serve to deny any anxiety associated with either intimacy or affection.

Other investigators have placed primary emphasis on the primitive emotional levels of familial interaction where unconscious factors play a decisive role. One such factor is the symbiotic relationship between mother and child so often cited in the earlier literature on schizophrenia. Wiedorn (1966), in employing a psychoanalytic approach to therapy with schizophrenic families, has found that disordered communications in the schizophrenic family serve to maintain an ongoing symbiotic pairing, most often with the mother. Hill (1955) believes that the symbiotic relationship between the mother and the schizophrenic child serves mutual needs on the part of both. In such a symbiosis the patient frequently comes to believe that by remaining sick, he preserves the mother's mental and physical well-being.

The present paper reports on the utilization of multiple family therapy in the treatment of young hospitalized schizophrenic patients. While we have no knowledge of this same approach being utilized for therapy elsewhere, the technique of seeing mothers of schizophrenic patients and their hospitalized offspring in a relatively large group setting is not in itself revolutionary. Instead, it may be considered a natural outgrowth of the recent work in group therapy, family therapy, and multiple family therapy described in various settings.

The idea of bringing together the mothers and the patients in the hospital in a collective setting involving approximately five patients and five mothers emerged from discussions among the staff of the hospital.

The original expectations of the authors were essentially as follows: (1) A group setting would provide structure and support for both the mothers and their offspring. (2) There would be some economy in staff time. (3) The group setting would make it possible for the mothers and patients to develop mutual identifications with one another. (4) The authors expected to be able to observe, *in vivo*, some of the pathological interactions between schizophrenic patients and their mothers. (5) Last but not least, the rehabilitation of these patients might be greatly facilitated by the open channels of communication between patients, relatives, and staff such a group would provide. Our expectations, by and large, were fulfilled, but what we had not foreseen was the extraordinary tenacity and cohesiveness that developed within this group, the explanation of which is at present more tentative than definitive.

DEVELOPMENT OF THE GROUP

The group was composed of four young female and two young male patients between the ages of 17 and 30 years and their respective mothers. The group met once weekly in the outpatient clinic of the hospital. The patients all resided on the same ward of the Admission Service, four of them being under the administrative care of one of the group leaders, while two others were in therapy with a resident assigned to the same unit. This resident was also an observer in the group. The two co-therapists who conducted the group meetings were a female staff psychiatrist and a male psychologist. The recorder was another resident also connected with the unit. At the onset of the group, the patients had all lived in the same ward milieu for over two months; as a consequence, they knew each other well and were familiar with each staff member. The group sessions, however, were clearly defined as separate from the ward milieu as a whole.

All but one of the patients came from a middle-class background. Two were immigrants. Four of the patients had lost their fathers, two of them by suicide. The two youngest members had not finished high school, two members had had two years of college, and the oldest member had a college degree. For four of the patients this was a first admission, while two had been hospitalized twice before. Four of the six patients had made suicidal attempts. Five patients were diagnosed as schizophrenic, one as borderline.

At the first meeting, all of the young patients lined up on one side of the room and the mothers on the other side. Each of the three factions (staff, mothers, and patients) sat close together and separate from the others. The usual phenomena of a beginning group were present, and questions as to time and the purpose of the group were raised. Within the first ten minutes the patients had united in anger against their mothers, quickly reaching a concensus that they had never felt themselves to be part of their respective families. Two of the girls described their feeling that nobody had ever cared about them as evidenced by the unlimited freedom they had been given. The two boys complained about being totally dominated by their mothers.

As a result of the rapid cohesiveness among the younger generation, one of the young male patients, a paranoid schizophrenic whom we shall call Dan, attacked the mother of one of the female patients for complaining about feeling helpless to cope with her daughter. This had come about in terms of the mother saying, "I don't know what to do any more. God only knows I've tried everything." Dan's sarcastic confrontation was, "Tell us what you have done." The mother, taken aback, said nothing, and the daughter then attacked with, "Mother, you fed and clothed me and sent me to school, but that was all you ever did." After her mother's response that, "Parents are only human," the other male in the group got up sufficient courage to accuse his own mother of having been domineering.

While the battle continued over the various ways in which the adolescents found their mothers wanting, Dan's mother, a rather attractive and seductive woman, seemed to be looking on gleefully at her son's aggressive performance. Her air of gloating did not change even when Dan put her on the witness stand, so to speak, and began attacking her rather viciously for her having been "so corrupt, sick, and domineering." In later sessions, it became more and more apparent that Dan was really afraid of any kind of close relationship with his mother and that his hostility served as a cover-up for his basic underlying dependency. This was one example of the "pseudohostility" described by the Wynne group (1958, 1961).

In subsequent meetings, among the important themes brought up, first and foremost seemed to be the issue of rejection. This was epitomized by the oldest female patient when she recalled that during one

of the few times in her life when she and her mother had been able to sit down and discuss things, her mother suddenly interrupted this brief moment of shared intimacy with the remark, "By the way, did you know that you were the result of a faulty diaphragm?" The mother at first totally denied ever having said such a thing, but later she conceded that she had thought her daughter was mature enough to accept this piece of information, thus acknowledging the truth of the daughter's allegation.

A strong issue in this group was the theme of suicide and murder. This was best exemplified by the question reiterated by this same patient's mother whenever any disagreement or unpleasantness arose between them: "What do you expect me to do, cut my throat?" In subsequent discussions on this theme, the suicide attempt of one of the male patients became a topic of interest. When the others in the group wondered if the suicidal attempt had possibly been directed at someone else, it came out that the suicidal gesture had indeed been aimed at an outside doctor whom the patient felt had offended him deeply by calling him "sadistic."

Still another issue was the importance of defining reality or the lack of it in the basic mother-child relationship. Once again Dan lucidly spelled out the innumerable ways in which his mother did not, in effect, permit him to experience his own reality. Instead, she chose to define it for him by running the family, making all of the important decisions, and even choosing all of his friends. As Dan put it, "All of the friends I ever had were my mother's friends, not my own."

After the rather traumatic exposure of a number of pathological issues in the first few sessions, some changes began to appear. In the sixth session, for example, two of the mothers sat next to their children for the first time. The mother of Ann Marie anxiously solicited the support of the group "in getting my daughter back." Ann Marie protested that although she did not want to "break off" her relationship with her mother completely, she felt she had to separate from her because her mother tried to infantilize her by lap-feeding her or by wanting to sleep in the same bed with her. There was a striking absence of embarrassment on the part of Ann Marie's mother when this material emerged. Instead, she talked about her own childhood deprivation, which opened up the theme of depression for the group as a whole. For the first time, dissatisfaction about the group and its goals appeared, and everyone began

making demands on the staff for explanations as to why they should continue coming to the group meetings. The same angry adolescents who had previously attacked their mothers now felt completely helpless.

Shortly thereafter, two of the female adolescents, who went A.W.O.L. during a ward trip to a museum, had to be transferred to the chronic unit of the hospital. In the following group session they sat sulking and complaining in somewhat paranoid fashion about the unit, claiming that they were called homosexuals and that the attendants tried to exploit them as sexual objects. Dan's mother made a positive remark to the effect that she wished to know more about how the two girls felt. One of the escapees, hitherto quiet, was then able to talk about her particular difficulties in communicating her feelings. She commented on her mother's (as well as her individual therapist's) absence from the previous session and stated that she felt just like she was "rotting away." Thereupon, Dan's mother, much in the way of a therapist, complimented her on being able to come out and talk about her feelings. This patient was later able to cry and to assert that she really was not as angry as she appeared but that she felt sad that others could think about returning to college while she remained relegated to the hospital's chronic unit. This same patient, some five months later, secured a job as a junior counselor in competition with several qualified applicants. She comes every second week to the group, while her mother attends every week.

After several months, both the adolescents and their mothers became increasingly supportive of the efforts the patients were making toward rehabilitation and eventual discharge from the hospital. There was a great deal of information-giving during this phase about such basic matters as finding suitable jobs, living arrangements, financial arrangements, etc. At about the same time, the group began to discourage aggressive exchanges between adolescents and their mothers. It was after this phase, marked by depressive issues and some acting out, that the adolescents began to show considerable improvement.

Because of the severity of their illness and the magnitude of the change in the equilibrium within their families, a patient's discharge from the hospital was not without influence on other family members. Dan's mother, who originally appeared to take vicarious enjoyment in her son's aggressiveness, became almost paranoid upon her son's discharge from the hospital. She contacted one of the group leaders to com-

plain how threatened she felt by her son's returning to live with her. With encouragement, she sought out counseling from a Family Service Unit near her home. Probably only through confrontation with her son in a supportive group milieu was she brought to the point where she could ask for help for herself. This in turn made it possible for one of the other mothers to discuss her own problems and her own feelings about her helplessness for the first time in the group.

At this writing, several months after the group began, all of the adolescents have been discharged from the hospital and all return regularly with their mothers to the group for further work on their problems. A shift of balance has occurred however, in that the hospital patients are no longer the only "patients" and the mothers are no longer able to maintain their stance of denial as easily as before. The latter have begun increasingly to do therapeutic work of their own. The remarkable thing is perhaps not so much the relatively quick discharge from the hospital of the adolescent patients as the fact that the schizophrenic pathology has yielded to a much more human interchange with more effective modes of participation. The group of mothers and ex-hospitalized patients has become similar to a therapy group in which human beings are able to help each other in solving problems more as equals than as parts of one another or as bitter enemies.

DISCUSSION

It is clear from the foregoing that this multiple family group was different in many ways from an ordinary therapeutic group. First, a high degree of cohesiveness was present in this group from its very inception. In ordinary group therapy, whether it be in a hospital or in an outpatient setting, cohesiveness only follows upon a relatively lengthy building process during which people test each other out. This procedure seems to have been greatly shortened, although certainly not passed through without some pain, in this particular group. The initial situation, with the adolescents lined up against the mothers, undoubtedly represented a trauma for the mothers, but it forced a "holding together," not only on the part of the patients but also on their mothers' part. It took some time until the mothers were able to support one another as they saw their children doing. In fairness, it must be said that a previ-

ously existing and predominantly positive relationship between two of the group leaders and some of the patients contributed to the cohesiveness of the group as a whole.

Second, as far as the working out of family dynamics is concerned, the group setting undoubtedly presented a challenge to some but was perhaps an obstacle to others. While some mother-child pairs made significant discoveries about themselves, others seemed to interact in much the same way after months of attendance in the group as they had before. Therapeutically speaking, it appears as if those mothers and children who fight with one another in the group have a better chance of making progress than those who show a more passive acceptance of one another. This, in turn, suggests that a multiple family group may be most useful for those patients and mothers who demonstrate available conflictual material and that in the passive constellation some mobilization of affect will need to take place before significant therapeutic gains can be made.

Third, as far as the rehabilitative aspects of the group are concerned, it became clear that the patients themselves were maintained in some ways by the group and that dependence on the hospital became legitimatized and acceptable by virtue of their participation in a hospital-sponsored function. A gradual return to the community was possible in that the adolescent patients could discuss their difficulties in readjusting to the community within the supportive framework of the multiple family group. In this particular regard, the multiple family group did not essentially differ from any rehabilitation-oriented group.

SUMMARY

The authors found that a multiple mother-patient group became rapidly cohesive and quickly negotiated the conflictual material outlined by many researchers who have investigated the family dynamics of schizophrenia. The rehabilitative aspects of group support and encouragement were readily visible, and all of the young hospitalized adolescents were discharged from the hospital at approximately the same time.

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The Effects of Group and Individual Therapy on Sociometric Choice of Disturbed, Institutionalized Adolescents

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Tʜɪs sᴛᴜᴅʏ ᴡᴀs ᴜɴᴅᴇʀᴛᴀᴋᴇɴ in an effort to compare the effects of group and individual psychotherapy on the interpersonal relationships of adolescents enrolled in a residential treatment center. Since reciprocation of friendships is considered to be related to good emotional adjustment (Davids and Parenti, 1958; Teele et al., 1966), it was predicted that participation in psychotherapy, and particularly in group therapy, would increase friendship and reciprocation of friendship choices. The difference between therapeutic conditions was anticipated since group therapy traditionally tends to focus more directly on interpersonal factors than does individual therapeutic intervention.

METHOD

Subjects

Ninety-eight preadolescent and adolescent boys ranging in age from 12 to 17, with a median age of 14, served as Ss. All 98 were enrolled at

the Mapleton Campus of The Devereux Schools, a residential treatment center in suburban Philadelphia. They were of average or above average intelligence and had been admitted to the treatment unit for remediation of learning difficulties concomitant with emotional disturbances. The largest single diagnostic category represented was that of personality disorder. The majority of these youngsters had been enrolled for at least one year when the study was initiated.

Procedure

Fifty-six of these Ss were assigned to group therapy in September of 1967, after returning to school following attendance at Devereux's summer camp and two weeks of vacation at home. Nine groups were formed, varying in size from six to nine members. Eleven therapists were employed. One therapist, whose training was primarily psychoanalytic, was individually responsible for the direction of two of these groups and was assisted in four others by three Postdoctoral Fellows in Psychology. The remaining four groups each had two cotherapists whose orientations were eclectic. In six of the nine groups, the cotherapists were of both sexes.

The remainder (42 Ss) were assigned to individual therapy, the traditional therapeutic procedure at that unit. A major portion of these Ss had one of the group therapists as their individual therapist.

Sociometric Data

Three sociometric criteria were used: (1) social criterion, (2) work criterion, and (3) rejection criterion. These criteria were defined by responses to the following questions: "List the names of (1) the persons in your unit that you would most like to have come to your birthday party, (2) . . . that you would most like to have work with you on a school project, (3) . . . that you would most *not* like to have sleep in the same cabin or tent with you at summer camp." These three criteria were not mutually exclusive since no restrictions were placed upon repetition of choices. Three measures of the dependent variable, sociometric choice, were employed: (1) number of choices given, (2) number of choices received, and (3) number of mutual choices.

At the time of pretesting, 80 Ss were enrolled on the Mapleton Campus. Of these 80, 74 completed pretesting, with six refusing to cooperate. Forty-seven of these 80 Ss had been assigned to group therapy,

29 to individual therapy, and four were yet to be assigned. Shortly following pretesting, the four unassigned Ss were assigned, along with five new enrollees, to a therapy group.

Eight months following pretesting, Ss responded again to the same three questions. Eighty-three Ss were present for this testing. Of these 83, 59 had completed and 24 had not completed the pretest (18 new students and the six who would not cooperate on the first testing). Of the 18 new Ss, three were enrolled in late September, four in October, three in November, two in December, two in January, three in February, and one in March.

Forty-nine of the 83 Ss posttested were in group therapy, with 40 of these Ss present on both testing occasions. Thirty-four of the 83 present were in individual therapy, with 19 of these present for both testing sessions. Fifteen Ss completed the pre- but not the posttest. Of these 15, 10 were transferred to another unit or withdrawn from the school and five refused to cooperate.

Several differences should be noted between the conditions prevailing at the time of the two testing periods. During pretesting, all Ss were tested in a single large group and those refusing to cooperate were ignored. During posttesting, Ss were tested in two groups, but since the number refusing to cooperate was large ("We've done this before! I'm not going to camp!"), a number were retested as a group on a separate occasion (22 of 27 were retested, with five still refusing to cooperate).

At both testing sessions, the instructions were read aloud by the examiner. On the pretest, responses were recorded on 5" x 8" cards, while posttest responses were written on 8½" x 11" paper on which the questions were written and space provided for answers.

Statistical Analysis

The data for all 98 Ss present at either testing session was analyzed in the following manner. Responses to each of the three questions were analyzed separately for each treatment group on each of the three criteria: choices given, choices received, and mutual choices. For example, the number of choices received by each S in group therapy on the social criterion was calculated for both the pre- and posttests. (The number of choices ranged from 0 to 20, with mass choices given in several instances, a mass choice being a general, nonspecific response such as "everybody"). The pre- and posttest data was pooled and the median

number of choices determined. The number falling above this median on the pretest was then compared with the number on the posttest employing the median test (Siegel, 1956). This same procedure was employed to analyze the choices received by Ss in individual therapy and repeated for the other two dependent variables and then for the two additional criteria.

A second analysis compared the pre- and posttest data of only those Ss present at both testing sessions. In addition, direct comparisons were made of the two treatment conditions, first on pre- and then on posttesting.

The third phase of data analysis was a comparison of pre- and posttest choices given by Ss in group therapy. Choices on the social and work criteria were analyzed to determine if the number of posttest choices given to Ss within the individual's therapy group exceeded the number of choices given to Ss outside that group. This analysis was performed to determine whether group therapy solidified friendships within the group at the expense of friendships with nongroup members.

The fourth phase was an analysis of the degree of stability of choices given on both testing occasions. This analysis was included to determine whether individuals chose the same or different individuals after the eight-month period. The following formula was employed to measure this consistency:

$$\% \text{ consistency} = 100 \text{ X} \frac{2 \text{ X no. of same choices given}}{\text{total no. choices given on each occasion.}}$$

In addition, the degree of similarity of choices given to each separate criterion was analyzed utilizing the same formula. This analysis was included to measure the degree to which Ss chose the same individuals for both the social and work criteria. To test for significance of differences between percentages, the procedure described by Croxton and Cowden (1939, p. 337) was employed.

RESULTS

A general inspection of responses to the social criterion indicated that although the number of choices given and received was about what would be expected from children this age (median given 5, received 4), the number of mutual choices was low. On the posttest, sixteen Ss had

unreciprocated choices and the median fell at one reciprocated choice. These figures are similar to those obtained on the pretest, except that the isolates were generally not the same Ss.

A comparison of treatment groups revealed little difference between them on the social criterion. Ss experiencing only individual therapy gave more choices on post- than on pretesting ($n = 27$ on pre-, 34 on post-; $X^2 = 5.01$, p < .05), while this did not occur with those in group therapy.

Differences were demonstrated on the work criterion. Ss in group therapy significantly increased in number of choices given ($n = 47$ on pre-, 49 on post-; $X^2 = 4.61$, p < .05), choices received ($X^2 = 3.93$, p < .05), and mutual choices ($X^2 = 3.36$, p < .10), while those in individual therapy only received more choices ($X^2 = 6.32$, p < .02).

On the rejection criterion, Ss in both treatment groups tended to reject more students on post- than on pretesting (group therapy $X^2 = 2.92$, p < .10; individual therapy $X^2 = 3.40$, p < .10). No other differences were apparent, either within or between groups.

Comparison of only those Ss from the two treatment groups who were present on both testing occasions revealed the following. Within the group of Ss having group therapy, findings were similar to the previous analysis. The one exception was the failure of an increase in choices received on the work criterion to reach conventional levels of significance ($X^2 = 1.90$, p < .20). The increase in mutual choices on the work criterion reached significance at the five per cent level ($X^2 = 5.13$), as did the increase in choices given.

Findings within the group of Ss having only individual therapy were somewhat different from the first analysis. On the work criterion, there was a significant increase in choices received ($X^2 = 7.71$, p < .01) and mutual choices ($X^2 = 2.78$, p < .10). There was also a significant decrease in number of choices received on the social criterion ($X^2 = 6.81$, p < .01). A between-group comparison of posttest results revealed that Ss in individual therapy received fewer choices ($X^2 = 9.33$, p < .01) and gave fewer choices ($X^2 = 17.68$, p < .01) on the social criterion than did Ss in group therapy.

An analysis of changes of choices within the group of Ss in group therapy revealed the following. No significant changes in intragroup choices occurred on the social criterion. On the work criterion, however, there was a tendency toward an increase in the proportion of choices given to Ss outside the individual's own therapy group ($X^2 = 3.25$, p <

.10). On the rejection criterion, there was a significant decrease in the proportion of rejections given to Ss in therapy groups by their fellow group members ($X^2 = 7.30$, $p < .01$).

The mean per cent constancy between pre- and posttesting for the social criterion was 24.20 for those in group therapy (n = 40) and 28.51 for those in individual therapy (n = 19). These figures for the work criterion were 14.16 and 19.02 respectively; for the rejection criterion, 9.66 and 16.79. They indicate that the majority of Ss, regardless of the therapy condition, did not select on the posttest the same individuals selected on the pretest. The differences between the two treatment conditions were not significant.

The degree of overlap between the social and work criteria is depicted by the following mean percentages: group therapy Ss (n = 40), 51 per cent on pretest, 64 per cent on posttest; individual therapy Ss (n = 19), 48 per cent pretest, 51 per cent posttest. The differences between the percentages of the two treatment groups were not significant. The magnitude of these percentages imply that the social and work criteria are not independent, since nearly half the selections made on one criterion were also made on the other.

DISCUSSION

Of considerable interest was the relatively little change which occurred on the social criterion, while significant changes were demonstrated on the work criterion. This is even more remarkable considering the degree of overlap between the two criteria. The tendency for student-patients in group therapy to make more post- than pretest choices compared to those in individual therapy and to have more reciprocated choices is particularly interesting. Evidently group therapy is experienced as a work-oriented activity by these youngsters, and such experiences are viewed more positively after mutual participation.

The finding that Ss in individual therapy received but did not give more choices on the work criterion implies that the major portion of this increase came from Ss in group therapy seeking relationships with student-patients outside of their group. The finding that Ss in individual therapy gave more choices on the social criterion than did those in group therapy also implies some qualitative differences between the two therapy experiences.

The tendency of Ss in both groups to reject more students after eight months of therapy perhaps reflects increased self-confidence and improved social perceptiveness resulting in less tolerance for social deviancy.

The analysis employing only those Ss present for both testing sessions tempers some of these statements since the 19 Ss in individual therapy tended to receive more reciprocal choices on the work criterion after the eight-month period. That Ss having individual therapy received fewer choices on the social criterion implies, however, that perhaps these Ss became somewhat more isolated than others. Ss in group therapy rejecting one another less after such an experience supports this assumption.

The increase in proportion of choices given by group therapy members to individuals outside their own therapy group, although not significant at conventional levels, is an encouraging finding. It implies that group therapy in a residential treatment center does not just affect relationships within the therapy group to which the individuals belong but also their interpersonal relations outside of that group.

The relative inconsistency of choices across the eight-month period raises some interesting questions. Did the eight-month period of therapy result in a change in choices due to changes in social perceptiveness, or did this inconsistency merely reflect an inability to make objective and realistic judgments of the behavior of others, causing frequent changes in choices (Laing and Chazan, 1966)?

Keeping in mind that the therapeutic intervention was only for an eight-month period, the findings are encouraging. It would have been interesting to compare a third group of youngsters having no therapy experience with these other two groups. Perhaps some of the changes were due to the therapeutic milieu, but it is unlikely that they all could be attributed to this effect. The majority of Ss had been in residence for at least a year prior to the study, during which time only one therapy group was initiated. Impressions of the nonprofessional staff support the notion that the changes were due to group therapy.

This study, although suffering from several procedural difficulties, points to the value of employing group therapy in institutional settings. At best, participation in group therapy has a more significant impact upon interpersonal relationships than does individual therapy. At worst, there was no evidence that participation in group therapy was an inferior experience to individual psychotherapy.

SUMMARY

Ninety-eight adolescent and preadolescent boys enrolled in a residential treatment center were Ss in a study designed to determine the effects of group and individual therapy on interpersonal relationships. The adolescents participating in group therapy were studied sociometrically and compared with similar studies of those receiving individual psychotherapy. The results indicated that the Ss in group therapy improved their interpersonal relationships to a greater degree than did those in individual therapy, particularly their work-oriented relationships.

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Talking It Out Rather Than Fighting It Out: Prevention of a Delinquent Gang War by Group Therapy Intervention

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THIS PAPER WILL DISCUSS a group psychotherapy experience with adolescent delinquents who showed marked patterns of aggressive and hostile behavior. A crucial session in an ongoing delinquent adolescent group will be described in order to illustrate a successful attempt at preventing a gang war by group therapy intervention. This session was the culmination of many sessions directed toward helping these adolescents to modify the overt expression of aggressive impulses.

CLINIC SETTING

The therapeutic approach was carried out in a children's psychiatric clinic which provides individual and group therapy on a low fee basis for the lower socioeconomic, primarily Catholic, population of Bronx County, New York. The group referred to here was composed of delinquent male adolescents, between the ages of 13 to 16, who had been referred to the agency by the Bronx Juvenile Term Court. Outpatient treatment had been recommended by a court psychiatrist, and participation in treatment was a condition of their parole. A variety of diag-

nostic types were represented (including passive-aggressive personality, borderline reaction, character disorder).

THE ROLE OF THE GROUP THERAPIST WITH DELINQUENTS

Delinquent adolescent males need a positive therapeutic experience with an adult authority figure in order to change their overt expression of aggression and hostility. The therapist attempts to function as a positive adult figure who provides a laboratory for the working through of negative feelings toward adult authority figures.

In the present group, the therapist strived to function as a caring, warm, giving adult who was interested in fulfilling realistic needs and enhancing self-esteem. At the same time, he also provided structure, organization, limits, firmness, and authority. This therapeutic orientation was implemented by several techniques:

1. Sector analysis, focused on the exploration and working through of aggressive and hostile feelings.

2. Emphasis on here-and-now episodes of aggression and hostility reported in the group sessions.

3. Encouragement of use of the therapist as a possible source of identification by employing a dress, manner, and style of speech relevant to adolescent modes of thinking and behaving.

4. Expression of positive and negative feelings was exemplified by the therapist "coming across as a person" in revealing his own experience in dealing with adolescent problems.

5. Demonstrations of caring and giving by the therapist, e.g., refreshments at group meetings, field trips, environmental intervention with clinic staff on behalf of the adolescents.

A significant example of environmental intervention occurred during the initial group sessions. The boys spontaneously spoke of their intensely negative feelings about their past experience with adult authority figures in institutional settings, such as school, court, etc. They vividly described the dehumanizing experience of the court situation and their reactions of lowered self-esteem, resentment, hostility, and frustration. The therapist used this opportunity to explore their present feeling toward the clinic, another institutional setting run by adult authorities and one symbolically connected to the court. The boys immediately verbalized general negative feelings. When the therapist asked for specifics,

they unanimously expressed dissatisfaction with the secretaries in the waiting room, reporting they were greeted in a very impersonal, gruff way, e.g., "What's your name?", "Sit down and wait." They intensely felt the absence of a friendly smile, a warm word. It reminded them of all the worst aspects of their experiences in court.

The therapist responded by saying that if this was indeed the case, it was the wrong way for the secretaries to behave and he would try to change the situation. After observing the secretaries' behavior with the boys and other clients, the therapist met with all office personnel and discussed with them the importance of their contribution to the helping relationship with the boys, the hypersensitivity of adolescents to rejection based on past negative experiences with adults, and the importance of friendliness and warmth in working with these adolescents. The secretaries responded very well and made a special effort to relate to the boys in the desired manner. The boys were quick to pick this up and spontaneously reported the positive change to the therapist. A wedge was made into the boys' negative perceptions of adults.

PREVENTING A GANG WAR

The group had been meeting weekly for about eight months when a group member, Johnny, brought in a plan to settle a personal dispute. He had been unjustly accused of demeaning a former girl friend by calling her a "whore." The girl's present boy friend had mobilized his gang, and Johnny had begun to activate his. The protagonists had agreed to fight it out. Johnny was convinced of the rightness of this plan, and when he presented it to the group and the members challenged it immediately, he was noticeably shaken. He angrily asked the group to "come up with something better" in the way of handling the situation.

Before reacting to his plea, the group members spent a period of time challenging and ridiculing his idea of violence as a solution. Then with the help of the therapist, they began to explore the entire dispute. They suggested that Johnny had not done enough to prove his innocence, that his present behavior of going along with the gang war could be interpreted as an admission of guilt. Violence and acting out were pointed out to be the prime vehicle for his settling any form of dispute, whether large or small. Reports of such past behavior and its negative consequences emerged. Peaceful, nonviolent means of handling the situ-

ation were discussed, and the group, in collaboration with the therapist, formulated a plan to settle the dispute by "talking it out," in a small group situation in which only the girl, the girl's parents, the boy friend, Johnny and a friend of his (for support) would be present.

By the end of the session, Johnny had allowed the group to reach him; he reformulated his fighting-it-out plans, added to the now talking-it-out plans in a constructive way, and decided to put these ideas into action that same night. The therapist asked Johnny to call him the next day and give him information of his progress in settling the dispute. The group session ended with the boys wishing him luck.

The social crisis of a gang war was averted due to Johnny's peace-making efforts. This incident had significance for Johnny's friends outside the group sessions since it demonstrated to them a new way to handle conflict, and in the group sessions, from then on the incident was used by the therapist and the group members to reinforce the value of talking it out rather than fighting it out.

SUMMARY

The successful resolution of a potentially violent act of gang war is obviously a complicated matter. In this instance, it resulted from a combination of factors, some of which were fortuitous perhaps.

The group therapy situation allows the here-and-now experiencing of a positive father figure in the company of one's peers where the experience can be tested, validated, shared, understood, and owned.

The specific group member under discussion appeared to be struggling with an identity crisis. Would he identify with aggression and hostile acting out as a young tough, or would he identify with the therapist and begin to value talking out a problem and searching for peaceful solutions to conflict? Because of the availability of group therapy intervention in a crucial time in his life, he and the group were provided with an alternative way of being.

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Book Reviews

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GROUP DYNAMICS: RESEARCH AND THEORY, THIRD EDITION. Edited by *Dorwin Cartwright* and *Alvin Zander*. New York: Harper & Row, 1968. 580 pp., $11.95

The first edition of this standard text was published in 1953, the second in 1960. Between each edition lies a period of about seven years. In comparing the three editions the researcher (and this text is primarily for the researcher of group dynamics and theory) will be amazed at the changes that have taken place in sociological and psychological concepts in the field of group dynamics. These changes include the power and influence of groups, leadership, the structure of groups, the homogeneity and membership of groups, and a relatively new aspect, the motivational processes of groups.

The editors do not fail to pay homage to Kurt Lewin. "The persuasive influence of his work upon our thinking should be too obvious to require detailed citation." For those readers engaged in the practice of group psychotherapy, reading the epoch-making experiments of Lewin and his "field theory" articles will enrich their understanding of this third edition, regardless of whether the group therapist adheres to the psychoanalytic or some other method.

The third edition of this text is as much a "must" as each of the former editions are. Those readers who own either the first or second edition are advised to keep their copies and to add this present edition to their library.

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THE PERSON: HIS DEVELOPMENT THROUGHOUT THE LIFE CYCLE. By *Theodore Lidz.* New York: Basic Books, 1968. 574 pp., $10.00

This encounter with Dr. Theodore Lidz, through his book *The Person,* is an entirely pleasurable one. The book reads easily, states matters clearly and concisely, and conveys a great deal of knowledge about a great number of things. It may become something of a standard text for courses in ego psychology, psychiatry, and social work. The book is aimed at a broad audience of people in the helping professions and is skillfully written in such a way as to offer a great deal to the uninitiated but also enrich the person experienced in one of the mental health fields. The simplicity of presentation and the richness of the content make this book something of a *chef d'oeuvre.* Bringing together the relevant material from psychoanalysis, child development, the social sciences, and psychosomatic medicine from the point of view of the individual going through the successive stages of life, it is, of course, a book on normal development that does not set any normative standards. The psychiatrist may wish to hear more from Lidz on pathological development, but the author says time and again that such issues fall beyond the scope of this book.

The plan of the book is a relatively simple one: after three introductory chapters outlining some of the theoretical bases for his knowledge, Lidz takes us on a guided tour from birth through childhood, adolescence, mature life, old age, to death. All the pertinent issues in individual development, family development, and social development are covered; the challenges, the hazards, pitfalls, and achievements of each stage in life are clearly before us. Three final chapters include one on life patterns, i.e., those features which continue through all or most of life stages, one on psychosomatic correlations, and one on the therapeutic relationship.

Three theoretical roots feed substance into the author's views and descriptions. They are (1) psychoanalytic theory, based on Freud's own writing, psychoanalytic ego psychology, and Erikson's concept of the life cycle. (2) Piaget's theories of the child's intellectual development, which is particularly important to the author's treatment of childhood development. It is surprising how Piaget's views could have escaped psychiatrists, particularly child psychiatrists, for as long a time as they have, and Lidz has done a service by giving them full consideration within the context of his chapters on child development. (3) Present-day knowledge of the social and behavioral sciences. Prominent findings from sociology, an-

thropology, and family interaction are included and provide relevant information at practically all junctures. It is no small task to bring information from such varied sources together and make one whole out of it. The ease of the discourse is deceptive, and it takes some thorough reading to appreciate the effortless way in which the author handles even the more complicated theoretical questions. This reviewer particularly enjoyed the footnotes in which very relevant theoretical material is often handled. Ample but not abundant reading lists are provided for each chapter of the book.

Lidz has no theoretical axes to grind and his writing on theory displays fairness to all and is without malice. It is in that sense an encyclopedic work and the opus of a true scholar. It provides a synthesis of much or most that is now available in the field of the mental health professions. It can be heartily recommended to both the beginner and the advanced professional.

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A HISTORY OF PSYCHOLOGY IN AUTOBIOGRAPHY, VOLUME V. Edited by *Edwin G. Boring* and *Gardner Lindzey*. New York: Appleton-Century-Crofts, 1967. 449 pp., $8.00

One of the last books to appear under the editorship of the late Edwin Boring, *A History of Psychology in Autobiography,* is an outstanding addition to a worthwhile series of publications the purpose of which is to collect the specially prepared autobiographies of major contributors to the field of psychology. Earlier volumes have included foreign representatives, but this practice has been discontinued for the present issue.

Included in this edition, Volume Five, are the autobiographies of Gordon Allport, Leonard Carmichael, Karl Dallenbach, John Dashiell, James Gibson, Kurt Goldstein, J. P. Guilford, Harry Helson, Walter Miles, Gardner Murphy, Henry Murray, Sidney Pressey, Carl Rogers, B. F. Skinner, and Morris Viteles.

The sketches tend to average thirty pages each, and each writer has achieved, in addition to his scientific contribution, a style of some distinction. This alone is enough to justify the series. The flavor of presentation has evolved over the course of the five volumes. The speakers in Volume Five present themselves more as individual people and less as producers of scientific research. In so doing, they have generally given a fuller

picture of themselves and have enhanced the value of the autobiographical series.

The full-page autographed photographs in this edition provide an improvement over the smaller unautographed photos in the earlier issues of the series. On the other hand, it is a loss that the present volume has not been indexed. However, even more important is the increasing emphasis on personal material in the biographies as opposed to professional items. The current conception of what should be included in a professional biography has been broadened considerably since the earlier editions of this series, much to the benefit of the newest volume.

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THE TREATMENT OF FAMILIES IN CRISIS. By *Donald G. Langsley* and *David M. Kaplan*. New York: Grune & Stratton, 1968. 184 pp., $7.50.

These authors have accomplished a great deal by compressing into a small book a first-hand research and clinical experience with families in a decompensation crisis. Though they recognize and are clearly familiar with the major contributions to, and theories of, family therapy of various types, they eschew theory in favor of reporting their work in practical and concrete terms. This is the first of two planned books on the treatment of 186 families in crisis (with controls and follow-up) primarily to prevent hospitalization.

In this book the authors, who were part of a shifting multidisciplinary (cotherapy, collaborative, and supplementary) team of mental health workers, describe their clinical approach and some representative experiences with families in crisis who were on the way to admitting one designated family member as an inpatient to the Colorado Psychiatric Hospital. The second book will hopefully give an accurate evaluation of the therapy.

Families were selected for the study only after a decision to admit the patient was made by the emergency room resident. On a random basis the family was then selected for the experiment of family crisis therapy with the team, or the individual was admitted to the ward and entered the control list.

Once the family crisis therapy team entered the scene, there might be a family session immediately, with or without drugs for the designated

patient, a brief respite and then another meeting a few hours later with a new or additional team member, followed by a home visit, follow-up visits or a referral, until the crisis was settled and the decompensation interfered with successfully.

A brief outline of various approaches to mental illness as well as family therapy is presented. The model used here is that of the family physician in a medical emergency, with the family as the field in which the crisis occurs and as a valuable ally to its resolution. Their model of family treatment makes it a very active, directive one which utilizes many innovations brought into the psychotherapy field. These include multiple therapists, partial networks, home treatment, limited individual therapy, drug therapy, environmental maneuvering, early interpretations, large doses of support, relief from stress, efforts to decrease scapegoating, awareness of and dealing with transference, countertransference, and group phenomena, and allusion to therapeutic modifications with hindsight.

Their work includes an effort to evaluate a psychological test for the families along with matching control families for length of hospital stays and savings in money, time, and self-esteem.

In many ways this model may aid community mental health centers to fulfill their title designation. Although it does not deal with group therapy per se, it adds a practical dimension to family therapy. How many hospitalizations could be prevented if the crisis which is in conception were clearly diagnosed early and an emergency family therapy session arranged if necessary at 2:00 A.M.?

This poses a larger question for the therapists outside a training hospital than the authors dwell on.

<div style="text-align: right">

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POETRY THERAPY. Edited by *J. J. Leedy*. Philadelphia: J. B. Lippincott, 1969. 288 pp., $7.00.

On reading the comments upon the bright dust jacket of this book, one is struck momentarily with a terror that the muse might not survive the onerous duties about to be imposed. Was it not to be expected that environmental ruin would have its psychological analogue? As industrial giants pollute our air, so do well-meaning but ambitious intellectual activists pollute many of our worlds of imagination.

There are brave beings who would fancy themselves able to "apply"

that which none can understand in that other similar creative effort of therapy: to "apply" not in a sense of awe and beauty but in the despairing sense of techniques, dosages, and cure-rates. How much and which type of poetic beauty shall we "apply" to heal schizophrenia (that poetic and terrible word that describes something whole shelves of books seem to make no clearer)?

At its best, treatment becomes poetic in the sense that psychotherapy is understanding honed to its keenest human edge. What is to be feared from books like this is the temptation to the will to usurp the place of imagination, the opportunity offered for utility to replace beauty. Any wilful attempt to "treat" by quoting a line memorized for a contrived occasion will inevitably remain outside full poetic (and therapeutic) context.

Fortunately, the prejudgment is only partially confirmed. Many of the 22 essays in this volume transcend the deadly and destructive utilitarian conception indicated by the cover, foreward, preface, and introduction. Most say something imaginative, beautiful and useful. Many are fine critical notes, touching clinical vignettes or full of excellent original poetry. Several are especially worth mentioning.

The opening chapter by Robert Jones is a fine example of therapeutic strategy in which a relationship finds itself and develops in its own way. The poetry is expressive but incidental. The chapter by Milton Berger is a thoughtful discussion of the relation of poetry to treatment. Several specific poems as they come to mind in specific therapeutic situations are offered.

Morris Morrison, a teacher, offers brief histories of four troubled adolescents who required home instruction because of illness. In one the study of a poem produced unexpected results. For the other three personal poetry led to changes and described states of being otherwise beyond reach.

Harold Greenwald's chapter consists mainly of three case examples, each offering such excellent and exquisitely descriptive poetry that one suspects they were written by professionals. From Sybil's hopeless and passionate entanglements, through Lewis's descriptions of his problems, his history, and his transference, to Glenda's sassy criticality, each is given striking and lifelike description in personal poetry.

The chapter by Smiley Blanton was completed after his death. There are unusually numerous death references in the chosen poems, so touching and profound as poetic harbingers of death that one pays little attention to the mildly maudlin and evangelical tone.

Sue Robinson and Jean Mowbray describe the history and experience

of publishing a hospital newsletter and the significance of poetry as part of it. They come closest to describing the best use of this art form: "Although the significance of poetry was never formally discussed, its healthy effects were apparent." The patients expressed themselves in poetry because that seemed a natural thing to do. "Poetry, then, of all the arts, comes closest to the therapeutic hour in psychoanalytic terms."

Unfortunately, not all of the essays are of a quality consonant with the above, and some are disappointingly true to the ambitious activism indicated on the cover.

Learn poetry, think and enjoy it, try to understand and write poetry, and it will be there when the fitting moment arrives. Trying to "apply" and "administer," on the other hand, must lose that immanent value which is the very thing being sought in poetry and in therapy.

This book is strongly recommended for all psychiatric libraries, both public and private. It is a book to which one will return for the many fine essays and poems and for the entirely accidental (?) confrontation between the formulated-utilitarian and the emergent-creative points of view.

PAUL F. EGGERTSEN, M.D.
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MODERN WOMAN: HER PSYCHOLOGY AND SEXUALITY. By *George D. Goldman* and *Donald S. Milman*. Springfield, Ill.: Charles C Thomas, 1969. 275 pp., $10.50.

This is the first volume in the Adelphi University Postdoctoral Program in Psychotherapy Conference Series. It contains some very good presentations of biological, psychological, social, and research data concerning women, followed by some equally provocative discussions. The list of contributors is impressive. Seven of the nine position papers are written by women. This seems entirely reasonable. Let the women speak for themselves. And indeed they do.

Edrita Fried asserts that women are less afraid to make love than are men. A woman can give herself up to abandon with less restraint than can men. Fried says this is the way the woman is brought up. Difficulties in being close to a man occur when she has had "bad" parenting, which is remediable through psychotherapy.

Leah Cahan Schaefer confirms this position and indicates that frigidity is a consequence of the inability of the woman to experience

pleasure. As Ernst Kramer points out in the catchy title to his discussion, her paper may be summarized in the question, "Orgasm: Enforced or Optional?"

Rose Spiegel suggests that women may be more prone to depressive states. Melanie Klein would probably confirm this. Spiegel is very cautious but the thrust is nevertheless there. She discusses especially the depressions related to conception and childbearing.

Elaine Grimm focuses her attention on women's attitudes and reactions to childbearing. Here, too, current and past interpersonal relationships are seen as primary determinants in good or faulty coping with the major crisis in woman's life, namely, becoming a mother. Although both Spiegel and Grimm suggest some biological determinants, both really stress the attitudinal aspects. Grimm is concerned about *this* pregnancy, with *this* man, at *this* time.

Ruth-Jean Eisenbud presents the life of the Lesbian in its "sweetest" aspects. It is the homophile's way of perpetuating an infantile sexuality in "fantasy, illusion, and make-believe." Such inner necessity encourages depression and mental breakdown. The world of reality becomes impossible. The possibility of successful adjustment to the life of the Lesbian is regarded by Eisenbud with dire pessimism.

Maria Bergmann sees promiscuity in women as one more consequence of "bad" child-rearing. The child is not permitted, not encouraged to separate from the mother. Such a child does not feel secure in developing lasting relationships with other persons. The dreamboat, the ideal, or the search for the beloved, according to most of these writers, lies at the root of frigidity, promiscuity, Lesbianism, depression and just plain unhappiness in women.

Selma Guber, on the other hand, rejects Freud's dictum, "anatomy is destiny." She promotes revolution. Guber sees the situation of woman in the United States as similar to that of the Negro and suggests womanpower as a response to legal, social, and personal enslavement. Guber sees woman's resistance to overcoming her minority role as a cultural neurosis demanding social action.

Only the two men who made major presentations have an optimistic, positive view about what it means to be a woman. Sheldon Waxenberg says that the prototype of human sexual functioning is female, not male, and that the woman is far better equipped sexually than is the man. He seems to hold his breath when he reports, "The female's capacity for orgasm is greater than the male's—on the order of a maximum of fifty orgasms in an hour (even at slack times!) for the mature female to perhaps a dozen in an hour for the male in his peak teens, with sharp

decline in potential ensuing into his following decades." Waxenberg is to be applauded for his excellent review of the hopeful possibilities in biological research for a woman to live out a full and fulfilling life, to be able to transcend the traditional bias that to be a woman is to be doomed to suffer.

Henry Guze also sees the biological as more central even in the formation of body-image, that is, the awareness of self in the woman. But he is concerned about the effects of the culture of the pill. If women are freed from the shackles of the physiology of reproduction, there will be role confusion. "If fad and fashion in clothing reflect certain cultural readiness, then it may be that as the distinctness of the male and female role in society is minimized, there is a compensatory accentuation as a caricature of the sexes. Thus one has to try a little harder to be a member of a given sex. Is the woman who is young to fantasy herself as a powerful, big-bosomed, big-buttocked Amazon who, in a Gaston Lachaise manner, challenges the atmosphere? if this is so, the male seeking to establish his own need for power and status may complementarily seek the juvenile type of woman." Women, you are just doomed to failure, no matter what!

This review cannot end without mention of two additional items. First, there are many stimulating and valuable contributions by the other twenty participants in this volume, all but one of whom are men, who acted as discussants of the major presentations. Second, there is a richness of case material and clinical application that makes this book a must on the reading list of every psychotherapist.

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BASIC APPROACHES TO GROUP PSYCHOTHERAPY AND GROUP COUNSELING. By *George M. Gazda*. Springfield, Ill.: Charles C Thomas, 1968. 323 pp., $11.00.

INNOVATIONS TO GROUP PSYCHOTHERAPY. By *George M. Gazda*. Springfield, Ill.: Charles C Thomas, 1968. 310 pp., $12.00.

The author has done a very creditable job of organizing the basic conceptual models and methods of significant contributors in brief presentations. In both volumes he has used essentially the same chapter on the history and development of group psychotherapy and group counseling with reference to the "significant contributors."

The author makes more of Moreno than is reasonable and a great deal less of Slavson and of Wolf and Schwartz than is realistic, perhaps revealing a prejudice. While he presents the different points of view without any heavy-handed sponsorship of any particular point of view, his leanings show through subtly. He makes use of a chapter by Stoller in the book on "Innovations" in reference to the use of videotape without any reference to the work of Alger and Hogan, Gladfelter, or Berger.

In the section on group counseling, he alludes to the resistance of people in the counseling field to the concepts of group work because it is said that counseling was too personal for group. He does not take into account Slavson's resistance as evidenced in his view of group therapy as an ancillary process.

In reading these books, one has an appreciation of the many different people and fields which are influencing the development of psychotherapy and group counseling. The author does not explicate any basic conceptions of counseling in contrast to psychotherapy. One is left with the impression that counseling is decent therapy for decent people and that there is something indecent about psychotherapy for disturbed (indecent?) people.

Specifically, in the first book the bibliographies are adequate to give students who are interested in a particular viewpoint a definite direction in which to go. Certainly, Lazarus' bibliography on Behavior Modification Approaches is the most complete.

Gazda's position is "eclectic with learning theory overtones." He attributes concepts to some authors which could as easily be attributed to others because of their general acceptance in the field. Certain of his techniques come more from analytic and dynamic psychotherapy than from learning theory or counseling theories and techniques, e.g., he makes reference to the use of the group as the routine contact with the client and the use of an individual session only rarely and also discusses the helper-helped dimension of the psychotherapeutic process without reference to Wolf and Schwartz, who first referred to these issues in some of their explications of theory and methodology.

Moreno's exposition is like a can of worms. Incredibly, he equates the concept of monastery life with the concept of therapeutic community. Is this a reduction of mysticism to community psychiatry or the elevation of the latter to a religious practice? He justifies the need for psychodrama and "acting out" (not the psychoanalytic concept) as techniques to get to meanings beyond hallucinations, preverbal experiences, dreams, and fantasies as if the interpretation of nonverbal communications and psychosomatic communications is inadequate to achieve the same goal.

Wolf did the job succinctly in regard to group psychoanalysis. This is a warm, open, serious attempt to explicate his conceptual position. The approach is aimed at an analysis of resistance and transference and the working through of unconscious and genetic roots of current problems. His style is much in contrast to the magical literary style of Moreno.

Hora's exposition of the existential approach is a mumbo-jumbo of value-laden words without clarification. He reduces the group process to the intention of the participants to achieve "meaningful encounters" and "authenticity," but it is not clear how the group will bring about whatever these are. The aim of therapy is "ontic integration." He is overly critical of other philosophic, psychological, and clinical models, using words like "hypocrisy" to describe them. This is paradoxical because his own theory says "let others be."

Lazarus, in a beautiful condensation of behavior modification theory and methodology, is worth the price of the book. The focus is on observables and measurables, and it is unclear how concepts, ideas, and fantasies which are not behavioral communications fall in the realm of this therapy. They are put there by the rather slick term "internal sentences." Lazarus, in a "masterful evasion," accuses those who contend that the behavior therapist should confine professional activities to the application of environmental manipulations, desensitization, and other specific conditioning techniques of a "masterful evasion of the clinician's duties." The approach is symptom-oriented but the goals seem no different than Freud's description of psychological help, that is, the development of the capacity to love and to work. Acts are considered more potent than thoughts in changing human behavior.

Ginott covers both play therapy and activity group therapy. He deals with selection, grouping, aims, relationships, catharsis, insight, reality testing, and sublimation. The point of view is a mixture of psychoanalytic and other dynamic formulations. He outlines the physical setting, the nature of the therapeutic encounter, the usefulness of permissiveness, and the necessity of limits. He equates one-to-one therapy with depth and group therapy with dilution.

The teleo-analytic approach, contributed by Dreikurs and Sonstegard, uses open-ended groups of parents and children. It breaks down the magic of the one-to-one relationship. It seems to be a fair statement of the interpretation of intentions, the intellectual approach, and the learning approach dating back to Adler's work in Vienna.

Lifton's philosophy has its origins in those who have assumed a positive drive in individuals which is directed toward help. The phenomenological plays an important part in this approach. There is a status

denial insofar as the leader is concerned. The words therapy and thera-
pist seem to slide in and out with the concepts of leader and member.
This was true in Lifton's own book, *Working with Groups.* He states
that "good mental health in our society suggests the need for therapy
groups at all levels of society." Certainly, one can see the advantage of
education and growth experiences for all, but this is again an indication
of his lack of clarity of concepts of education vs. therapy.

The editor uses the concepts group counseling and group psycho-
therapy interchangeably. For him, therapy requires the voluntary desire
to change. However, with involuntary clients, if they stay and participate
long enough to permit themselves to experience therapeutic effects (?),
successful group counseling can be achieved. His concept of openness
implies that resistances and defenses are conscious processes. While he
has a very organized approach in his writing style, his conceptual model
seems loose.

In the second book, *Innovations to Group Psychotherapy,* the selec-
tions have been chosen because they "reflect a theoretical rationale and
so hold promise of enduring." These chapters were prepared by the
originators of the positions and include: (1) accelerated treatment, i.e.,
Corsini's Immediate Therapy in Groups and Stoller's Marathon; (2) mass
treatment, i.e., Gibbs' TORI Processes and Mowrer's Integrity Therapy;
(3) greater therapist involvement, i.e., Gendlin's Experiential Group
Psychotherapy; (4) special communication media, represented by Stoller's
focused feedback with video; (5) Innovative Family Therapy approach,
i.e., Satir's work on Conjoint Family Therapy; (6) innovations in regard
to children in groups, i.e., Ginott's Group Therapy with Preadolescents.

One wonders why he did not attempt to have MacGregor contribute
a chapter on the Team-Family approach which is certainly an innovative
group approach and would have fit the criteria for this book better than
some of the ones he selected which could as well have been contained
or were contained conceptually in the first book on basic approaches.

Corsini makes the claim that "psychotherapy need not be intermin-
able. . . ." Immediate therapy is a "rapid, conversion-like, constructive
personality change. . . ." His philosophy is loosely stated equalitarian-
ism: the therapist is a very active and "clever" person, the patient is his
own diagnostician. It involves an active treatment phase in which a
volunteer is put into a situation which will induce anxiety. The pro-
cedure is oriented toward outwitting resistances, permitting big, rapid
gains. We might call it an inverse inspirational approach which uses
severe criticism, dramatic support, etc., to elicit emotional crisis with
hope for some resolution that is more favorable. Along with Telstar,

man on the moon, supersonic transports, jiffy meals, and, in fact, instant everything, we now have instant therapy.

Stoller's marathon, the "pressure cooker," is a brief intensive therapy which was spawned out of sensitivity training labs. The group is highly idiosyncratic, depends on the leader's view of life, is a personal experience rather than a treatment, uses a private residence, and the wife of the therapist participates; it denies professionalism and yet a fee is charged.

The implication is that one can coerce one's characterology. The emphasis is on disorganization, guts, life *au naturel*, as if selectivity, tact, discretion, order, and other ego functions are foreign to the human condition. The underlying assumption is that if the unconscious, unreasonable, disordered, unoriented, and unselective is expressed, somehow growth will occur. On the other hand, most psychologies and most philosophies see growth as the ordering of disorder, the orienting of disorientation, conceptualization and abstraction from the concrete and other kinds of civilizing and humanizing experiences. The approach of Stoller says one becomes human by becoming unbecoming. He focuses on one trial learning, not distributed learning. He focuses on a cross-section of the life style on the assumption that the unit of life reflects the whole pattern. His references to outcome studies are vague.

Gibbs's Emergence Therapy is based on the idea that trust (T), openness (O), realization (R), and interdependence (I) are processes which are therapeutic, independent of the presence of a therapist, regenerative in character, and intrinsic to all normal life processes in humans.

The philosophy and concepts of psychological stability and growth are reminiscent of Carl Rogers. Exactly what is new, innovative, or original is not evident. Perhaps it is the language or explicit formulations which Gazda considers innovative. Nothing is said which has not been said hundreds of times by Rogers, Lifton, and many others. The bibliography is limited to the author's publications and a few others. The authors are revising a book-length manuscript entitled "The Emergent Group: A Study of Trust and Freedom" which will present the theory in detail. With a title like that it should sell like Grandma's cookies.

Mowrer's chapter is folksy and rambles over his explanation of social alienation as the essence of psychopathology. He suggests that early Christian monastic practices were designed to provide salvation to wayward souls who had lost the "way" of fulfilling human existence and claims they were a form of "psychiatry." The basis of cure was public

confession of sins, penance, the return of self-respect, and return to "community." It seems that the author depersonalizes and loses the distance between religious practices and psychological practices. No one would argue about man's responsibility for his own life choices, nor is the idea of self-help a new one to any psychological approach to helping man out of his unhappiness. The idea of the obsolescence of the helper (therapist, teacher, parent, or other) is accepted by all reasonable people. He says his approach has been "dubbed, not unfairly, 'AA for civilians'." It is a travesty to include such pseudo-philosophic, pseudo-religious, pseudo-psychological ramblings and rubbish in any serious volume on psychological theories and methods.

Gendlin and Beebe discuss experiential groups and list eleven ground rules which they have the patients study and use in groups. This approach is intended to cut across therapy and other group methods. The focus is on experience and group process and on spontaneity. It is not a clearly outlined theory of psychology or methodology but, rather, a few cookbook rules for group process.

The use of videotape recordings and focused feedback is handled by Stoller. He describes VTR as more dimensional than audio, though he tends to find it obtrusive and something which the group has to learn to overlook. He is apparently not familiar with some of the more sophisticated systems of fixed cameras, buried wires, and coffee-table console such as are used by Goldberg, McCarty and Reilly. It is a loose use of the concept of feedback in which verbal and nonverbal responses to some unit of behavior are replayed to the group as close in time as possible in order to create some new insight. He contrasts interpretation, which uses verbal confrontation involving a theoretical construct, with feedback, which is merely audiovisual replay. He explains that there is more feedback in groups and still more of it in VTR. He explains different types of camera set-ups, some of the complications and some of the advantages of such a system. No elaborate theory or methodology is explicated.

Satir, as the representative of family therapy, explains that a defective self-concept is at the root of emotional disturbances, that such defective self-concepts are learned and maintained and that psychotherapy is the behavior change art. She reduces things to five concepts: the family system, the growth model, emphasis on the present, the use of process as a diagnostic and change tool, the use of body and body parts as a direct means of integration of information.

Ginott points out that neither interviews nor play are suitable for preadolescents in the ten- to 13-year age range. These youths are either

oriented to acting out in a boisterous fashion and need to become more modulated or are overinhibited and need to be led to more vigorous outlets. He uses fire play for aggression, tape recorders, walkie-talkies, penny arcade machinery and other devices, all chosen for specific therapeutic purposes. There are many criteria listed for inclusion of or exclusion from the group, and essentially he expresses Slavson's attitude about the group as ancillary to individual therapy.

While the first book is representative of many of the basic approaches, as one would expect from the title, the second book does only a half-way job, both because of the selections and because the selections are not nearly as well organized in terms of content. Both books are useful as a handy reference to the basic models. They would be particularly useful in courses aimed at beginning surveys of the field of group therapy.

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Books Received

OCCUPATIONAL ACTIVITIES TRAINING MANUAL FOR SE-VERELY RETARDED ADULTS. By *Jay L. Zaetz*. Springfield, Ill.: Charles C Thomas, 1969 ($7.25) 105 pp.

THEORIES OF SCHIZOPHRENIA. Edited by *Arnold H.* and *Edith H. Buss*. New York: Atherton Press, 1969 ($6.95, $2.95 paperbound) 175 pp.

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MODERN PSYCHOANALYSIS OF THE SCHIZOPHRENIC PA-TIENT. By *Hyman Spotnitz*. New York: Grune & Stratton, 1969 ($7.75) 234 pp.

SOCIAL ORDER AND THE RISKS OF WAR: PAPERS IN POLI-TICAL SOCIOLOGY. By *Hans Speier*. Cambridge, Mass.: Massa-chusetts Institute of Technology, 1969 ($3.95 paperbound) 497 pp.

PATH TO PERMANENT PEACE. By *E. J. Pawlowski*. New York: Vantage, 1969 ($4.95) 248 pp.

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GROUP PSYCHOTHERAPY. By *Bo Sigrell*. Stockholm: Almqvist & Wiksell, 1968 (price unlisted) 256 pp.

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WISCONSIN STUDIES IN VOCATIONAL REHABILITATION. Edited by *George N. Wright*. Madison, Wis.: University of Wisconsin, 1968 (price unlisted).

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ON PSYCHOTHERAPY AND CASEWORK. Formulated by the Committee on Psychiatric and Social Work. New York: Group For the Advancement of Psychiatry, 1969 ($1.00 paperbound) 46 pp.

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THE RELATION OF THEORY TO PRACTICE IN PSYCHOTHERAPY. Edited by *Leonard D. Eron* and *Robert Callahan*. Chicago: Aldine, 1969 ($5.95) 176 pp.

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PAINTING AND PERSONALITY. By *Rose H. Alschuler* and *LaBerta Weiss Hattwick*. Chicago: University of Chicago Press, 1969. ($16.50) 195 pp.

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